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TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12862

1. PLACE OF DEATH a. COUNTY Prince Geo MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20a		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthum			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo General				d. STREET ADDRESS 6018 Naval Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLOYD ALLEN ADAMS				4. DATE OF DEATH Month Day Year Nov 30 1966			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 26 1911	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEE W ADAMS				14. MOTHER'S MAIDEN NAME Fannie Adams (Allgood)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 534-899643		17. INFORMANT Address marie adams - as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Coronary Thrombosis inst PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dayton Watkins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) DAYTON WATKINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11-30-66			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12.3.1960		22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home. 300.4th.st N E.Wash.D				ADDRESS 4th St N E Wash D		24a. REC'D BY REGISTRAR DATE DEC 2 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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12896

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12863

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant 29			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 606 62nd Place,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Joseph L. Armstrong				4. DATE OF DEATH Month Day Year November 3, 19 60			
5. SEX Male		6. COLOR OR RACE /W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30, 1920	
9. AGE (In years lost birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Francis Armstrong				14. MOTHER'S MAIDEN NAME Mary O' Donnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. W W 11 579 14 4086		17. INFORMANT Mildred A Armstrong Seat Pleasant, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.9 DUE TO Abdominal carcinoma toxic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of large bowel (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-31-60 to 11-3-60 that (I) (we) last saw the deceased alive on 11-2-1960, and that death occurred at 24 M, from the causes and on the date stated above.							
22a. SIGNATURE Jeanne C Bateman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-3-60	
22c. PHYSICIAN'S NAME (Type) Jeanne C Bateman				22d. ADDRESS 940-25 St NW, Wash DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 7, 1960		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) Suitland Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR NOV 9 60 DATE		25b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

13898

John O. Donnell

Donald's Farmington

WASHINGTON

WASHINGTON

Nov 2, 1900

Nov 2, 1900

Nov 2, 1900

Nov 2, 1900

Nov 2, 1900

Nov 2, 1900

Nov 2, 1900

Nov 2, 1900

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12864

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b. <u>dead normal</u>				d. STREET ADDRESS <u>14706-68th Place</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna Lou Barnett</u>				4. DATE OF DEATH <u>Nov 17 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 26, 1916</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>			
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Andrew Dalton King</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Whitten</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Joseph J. Barnett</u>				Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>acute pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Coronary arteriosclerosis</u> (c) <u>heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov 19, 1960</u>		22c. NAME OF CEMETERY OR <u>George Washington</u>	
23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>		DATE SIGNED <u>11-17-60</u>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12966

CERTIFICATE OF DEATH

12865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403-65th ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HANNAH E. BATTERS		4. DATE OF DEATH Month Day Year NOVEMBER 7 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3, 1878
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS YARROW CARTON		14. MOTHER'S MAIDEN NAME LYDIA MARY SMALLWOOD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT CAROLYN L. GALE Address 403-65th ST. MD. PK. MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, LEFT BREAST, WITH METASTASIS 170X DUE TO (b) CDRAUGHT Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, chronic			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 11, 1951 , to Nov 7, 1960 , that I last saw the deceased alive on Nov 5, 1960 , and that death occurred at 6:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest E. Cornelsen M.D.		ADDRESS (Street, city or town, state) 4400 BOWEN RD SE DATE SIGNED	
PHYSICIAN'S NAME (Type) ERNEST E. CORNELSEN		WASHINGTON 19, DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-10-60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Union		22d. LOCATION (City, town, or county) (State) Mays Landing NJ	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lee Sons Co ADDRESS 300-4th st N.E		24a. REC'D BY REGISTRAR DATE NOV 9 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12887
CERTIFICATE OF DEATH

12866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 5 yrs					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 903 Cox Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Nellie W. Beaver				4. DATE OF DEATH Month Day Year Nov 24 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 30 1872			
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) INDIANNA				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME LYMAN R. WILLIAMS				14. MOTHER'S MAIDEN NAME ALMA McCLUNG					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)					
17. INFORMANT WAYNE BENEDICT				Address 903 Cox Ave Hyattsville, MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Vascular Disease 7 yrs DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from June 1953 to Nov 24 1960, that I last saw the deceased alive on Nov 24 1960, and that death occurred at 9:30 AM, from the causes and on the date stated above.									
ACTUAL SIGNATURE Norman Donat Comenl M.D.				ADDRESS (Street, city or town, state) 3503 Penny St 11/24/60					
DATE SIGNED									
PHYSICIAN'S NAME (Type) NORMAN DONAT COMENL				MT RAINIER MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 11-26-1960		22c. NAME OF CEMETERY OR CREMATORY CEDARHILL CREMATORY		22d. LOCATION (City, town, or county) (State) SUTLAND MD			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Gorman, Inc. 1756 Pa. Ave NW Wash, D.C.				24a. REC'D BY REGISTRAR NOV 28 60		24b. REGISTRAR'S SIGNATURE Arthur S. Thompson			

15888

CONTENTS OF DEATH

W. M. A. T. 1911

W. M. A. T. 1911

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and in event within 72 hours after death, or its designated agent, prior to burial, cremation, or removal, and in event within 72 hours after death.

VS. A15ME
5M 7/59

12967
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
12867

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>			
c. LENGTH OF STAY IN 1b <u>3 years</u>				d. STREET ADDRESS <u>5512 - North Forest Edge Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rose Ella Bennett</u>				4. DATE OF DEATH <u>November 22 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 16, 1885</u>	
9. AGE (In years, last birthday) <u>75 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>James Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jane Richardson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Ethel Louise Cooper</u> Address <u>5375 Auth Rd Wash 23, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Haemorrhage</u> DUE TO (b) <u>Bronchiectasis, Bilateral lobar</u> DUE TO (c) <u>pneumonia - Pulmonary Tuberculosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>11-22-60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery, Suitland, Md</u>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>Summers Bros 1661 - 9th Hope Rd & E</u>				ADDRESS			
24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

MAINTAINING THE REPUTATION OF THE
FEDERAL BUREAU OF INVESTIGATION
AND THE UNITED STATES DEPARTMENT OF JUSTICE
15067



FOR THE DIRECTOR
JAN 21 1964

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.
M

MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
12898 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12868																			
1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Geo General</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>548 WYANOKE AVE</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA LAVINIA BENSON</u>					4. DATE OF DEATH Month Day Year <u>Nov 30 1960</u>														
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13 Jan 1870</u>		9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>GEORGE P. MORRIS</u>					14. MOTHER'S MAIDEN NAME <u>LOUISA WILHEM</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>NONE</u>					17. INFORMANT <u>MRS. J. R. BENSON</u> Address <u>337 GREENBOW BALTIMORE, MD</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.00 DUE TO (b) <u>arterial Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Generalized arterial sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> years years										PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>NO</u>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)												
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>														
EXAMINER'S NAME (Type) <u>Dayton O Watkins</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>														
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>														
					Address (Street, city, town, or county) <u>11-30-60</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>12/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>Freeland, Maryland</u>											
23. FUNERAL DIRECTOR <u>Wm. J. Tickney Sons</u> <u>Balto - 17, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>DEC 2 '60</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									

15808 MEDICAL EXAMINER CERTIFICATE OF DEATH

FOR STATE
DEPT. OF HEALTH

[Faint, mostly illegible text from the reverse side of the document, including fields for name, date, and location.]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12950

CERTIFICATE OF DEATH

Reg. Dist. No. 12869

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 605 Fairlawn Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Frederick Middle Wilson Last Besley				4. DATE OF DEATH Month November Day 8 Year 19 60											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1873 August 16, 1873		9. AGE (In years last birthday) 86 yrs. 1873		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor of Science				10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? 			
13. FATHER'S NAME Bartholomew Besley						14. MOTHER'S MAIDEN NAME Sara Wilson									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO Arteriosclerosis (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs 8 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 6/6 , 19 59 , to 11/8 , 19 60 , that I last saw the deceased alive on 11/8 , 19 60 , and that death occurred at 19 4 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Maryland DATE SIGNED															
ACTUAL SIGNATURE John M. Warren M.D.															
PHYSICIAN'S NAME (Type) John M. Warren, M.D., 305 Prince George Street, Laurel, Maryland															
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 11-10-60		22c. NAME OF CEMETERY OR CREMATORY Green Mount				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place								24a. REC'D BY REGISTRAR DATE NOV 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hana					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12899

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12870

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Richard E. Blake				4. DATE OF DEATH Month Day Year November 1 19 60					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 74? yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Odell Blake Mitchellville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis HT dis. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the head of the penis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Nov. 1, 60				20g. (County) Prince George's		20h. (State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from 11-1-60 to death Nov. 1, 60, that (I) (we) last saw the deceased alive on Nov. 1 - 19 60, and that death occurred at 1:40 PM from the causes and on the date stated above.									
22a. SIGNATURE Leonard H. Dietz				22b. DATE SIGNED 11-2-60					
22c. PHYSICIAN'S NAME (Type) Dr. Leonard Dietz, M.D.				22d. ADDRESS 5802 Baltimore Ave., Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 6, 1960		23c. NAME OF CEMETERY OR CREMATORY Carroll Church Cemetery			
23d. LOCATION (City, town, or county) Maryland				23e. (State) Maryland		23f. (Country) United States of America			
24. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart				24b. ADDRESS 30-H St. NE.		25. REC'D BY REGISTRAR DATE NOV 4 '60			
25a. REGISTRAR'S SIGNATURE Orlando L. Kline				25b. REGISTRAR'S SIGNATURE Orlando L. Kline					

1939

CERTIFICATE OF DEATH

Walter J. ...
October 20, 1939

Walter J. ...
October 20, 1939

Walter J. ...
October 20, 1939

12888

CERTIFICATE OF DEATH

Reg. Dist. No.

12871

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 29 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Bells Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY S. E. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 718 Brandywine S t. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JEFFERY THOMES BLOHM First Middle Last		4. DATE OF DEATH Nov. 14 1960 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1960
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR 2 Months 8 Days	11. IF UNDER 24 HRS. 8 Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas W. Blohm		14. MOTHER'S MAIDEN NAME Lahni M. Nicholson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas W. Blohm (Father)		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 754.5 IMMEDIATE CAUSE (a) nonogram DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart disease - multiple defects DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH birth on birth on	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/15 , 19 60 , to 11/14 , 19 60 , that I lost sow the deceased alive on 11/14 , 19 60 , and that death occurred on 11/14 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6905 Ball's Blk DATE SIGNED ACTUAL SIGNATURE Thomas A. Christensen M.D. PHYSICIAN'S NAME (Type) Thomas A. Christensen, M. D. Cardozo Park, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/15/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR NOV 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

1. *George*

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James A. Christensen, Jr.

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• *See also* 111640

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12968
CERTIFICATE OF DEATH

12872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2902 Fairlawn Street, SE				d. STREET ADDRESS 2902 Fairlawn St., SE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BERNARD Middle LEO Last BORGER				4. DATE OF DEATH Month November Day 15 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1889		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Plate Printer - US Gov't.				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Henry Borger				14. MOTHER'S MAIDEN NAME Appolonia Nau			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Ida M. Borger #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Glomerulonephritis DUE TO (c) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington				20g. (County) D.C.		20h. (State) D.C.	
21. I certify that I attended the deceased from 4/28/1947 , 19____, to 11/15/1960 , that I last saw the deceased alive on 11/11/1960 , 19____, and that death occurred at 12:30 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Collins				DATE SIGNED 11/15/1960			
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.				ADDRESS (Street, city or town, state) 322- H. Street, N.E. Washington 2, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.				ADDRESS 317 Pa. Ave., SE		24a. REC'D BY REGISTRAR NOV 18 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12900

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12873

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosalie Middle Brannon Last Brannon		4. DATE OF DEATH Month November Day 8 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-06
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 54 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME M. BRUCE PACE		14. MOTHER'S MAIDEN NAME VIRGINIA PERRYMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. YES	
17. INFORMANT VIRGIL BRANNON		Address SAME AS # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suppurative Peritonitis DUE TO Perforation of Bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compressed fracture of 1st lumbar vertebra DUE TO (c) 14 days.		INTERVAL BETWEEN ONSET AND DEATH 1 week.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell through ceiling of living room in her home.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10 - 1960 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) P.G.		20f. (City or town) (County) (State) P.G.	
21. I certify that (I) (this hospital) attended the deceased from 29 Oct. 1960 to 7 Nov. 1960 that (I) (we) last saw the deceased alive on 7 Nov. 1960 and that death occurred 11-12-60 from the causes and on the date stated above.			
22a. SIGNATURE Thomas G. Maloney		22b. DATE SIGNED 11-15-60	
22c. PHYSICIAN'S NAME (Type) THOMAS G. MALONEY		22d. ADDRESS 4814 71st AVE WOODLAWN, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-12-60	
23c. NAME OF CEMETERY OR CREMATORY GEDAR HILL CEMETERY		23d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md		25a. REC'D BY REGISTRAR NOV 10 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MEDICAL CERTIFICATION

2

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STATE OF TEXAS
COUNTY OF DALLAS

1900

Know all men by these presents, that _____ of the County of _____ State of _____ do hereby certify that _____ of the County of _____ State of _____ was born on the _____ day of _____ 1900 at _____ Texas.

Witness my hand and seal of office this _____ day of _____ 1900.

County Clerk

Notary Public

Notary Public

Notary Public

CERTIFICATE OF DEATH

12874

Reg. Dist. No.

12951

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 60 Mrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 1425 Sandy Spring Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Catherine Middle R. Last BRANZELL				4. DATE OF DEATH Month Nov Day 26 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 Oct 1888	
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Washington, D/C/	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No N/A				16. SOCIAL SECURITY NO. None		17. INFORMANT John F Branzell	
				4206 Newark Rd., Colmar Manor, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension heart change 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ none							INTERVAL BETWEEN ONSET AND DEATH 8m 2y
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____				20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from 11/20 , 19 60 , to 11/26 , 19 60 , that I last saw the deceased alive on 11/25 , 19 60 , and that death occurred at 11 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 314 Compton Ave., Laurel, Md. DATE SIGNED 11/26/60 ACTUAL SIGNATURE N B Stewart M.D. 314 Compton Ave., Laurel, Md. PHYSICIAN'S NAME (Type) N B STEWARD 314 Compton Ave., Laurel, Md. 11/26/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE NOV 29 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

CERTIFICATE OF DEATH

12301



CHIEF

Handwritten signature or name at the bottom of the page.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1290 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12876

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chenery</u>		c. LENGTH OF STAY IN 1b <u>19 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Upper Marlboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>			d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Isabelle</u> Last <u>Brookins</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-92</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>John Simms</u>			14. MOTHER'S MAIDEN NAME <u>Susie Simms</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Saucy</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>James I. Boyd</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>Nov. 11, 1960</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-14-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Church</u>	
22d. LOCATION (City, town, or county) <u>Upper Marlboro, Md.</u>		22e. (State) <u>Md.</u>		22f. (Country) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William F. Funch</u>			24a. REC'D BY REGISTRAR DATE <u>NOV 14 1960</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			24c. (City or town) <u> </u>		

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-10-1914

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CITY OR TOWN		COUNTY		STATE	
OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		NAVY SERVICE	
CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE		CITY		STATE	
SIGNATURE OF CORONER		DATE		PLACE		CITY		STATE	
SIGNATURE OF JURY		DATE		PLACE		CITY		STATE	
SIGNATURE OF WITNESSES		DATE		PLACE		CITY		STATE	
SIGNATURE OF FUNERAL HOME		DATE		PLACE		CITY		STATE	
SIGNATURE OF BURIAL PLACE		DATE		PLACE		CITY		STATE	
SIGNATURE OF INTERMENT		DATE		PLACE		CITY		STATE	
SIGNATURE OF RECORDS		DATE		PLACE		CITY		STATE	
SIGNATURE OF VITALS		DATE		PLACE		CITY		STATE	
SIGNATURE OF DEATH		DATE		PLACE		CITY		STATE	
SIGNATURE OF BIRTH		DATE		PLACE		CITY		STATE	
SIGNATURE OF MARRIAGE		DATE		PLACE		CITY		STATE	
SIGNATURE OF DIVORCE		DATE		PLACE		CITY		STATE	
SIGNATURE OF WILLS		DATE		PLACE		CITY		STATE	
SIGNATURE OF PROBATE		DATE		PLACE		CITY		STATE	
SIGNATURE OF ESTATE		DATE		PLACE		CITY		STATE	
SIGNATURE OF TRUSTS		DATE		PLACE		CITY		STATE	
SIGNATURE OF PARTNERSHIPS		DATE		PLACE		CITY		STATE	
SIGNATURE OF CORPORATIONS		DATE		PLACE		CITY		STATE	
SIGNATURE OF SOCIETIES		DATE		PLACE		CITY		STATE	
SIGNATURE OF ASSOCIATIONS		DATE		PLACE		CITY		STATE	
SIGNATURE OF UNIONS		DATE		PLACE		CITY		STATE	
SIGNATURE OF TRADES		DATE		PLACE		CITY		STATE	
SIGNATURE OF INDUSTRIES		DATE		PLACE		CITY		STATE	
SIGNATURE OF AGENCIES		DATE		PLACE		CITY		STATE	
SIGNATURE OF INSTITUTIONS		DATE		PLACE		CITY		STATE	
SIGNATURE OF SCHOOLS		DATE		PLACE		CITY		STATE	
SIGNATURE OF COLLEGES		DATE		PLACE		CITY		STATE	
SIGNATURE OF UNIVERSITIES		DATE		PLACE		CITY		STATE	
SIGNATURE OF RESEARCH		DATE		PLACE		CITY		STATE	
SIGNATURE OF DEVELOPMENT		DATE		PLACE		CITY		STATE	
SIGNATURE OF INNOVATION		DATE		PLACE		CITY		STATE	
SIGNATURE OF PROGRESS		DATE		PLACE		CITY		STATE	
SIGNATURE OF ADVANCEMENT		DATE		PLACE		CITY		STATE	
SIGNATURE OF IMPROVEMENT		DATE		PLACE		CITY		STATE	
SIGNATURE OF BENEFIT		DATE		PLACE		CITY		STATE	
SIGNATURE OF WELFARE		DATE		PLACE		CITY		STATE	
SIGNATURE OF HEALTH		DATE		PLACE		CITY		STATE	
SIGNATURE OF MEDICINE		DATE		PLACE		CITY		STATE	
SIGNATURE OF SURGERY		DATE		PLACE		CITY		STATE	
SIGNATURE OF DENTISTRY		DATE		PLACE		CITY		STATE	
SIGNATURE OF OPTIC		DATE		PLACE		CITY		STATE	
SIGNATURE OF PODIATRY		DATE		PLACE		CITY		STATE	
SIGNATURE OF NURSING		DATE		PLACE		CITY		STATE	
SIGNATURE OF PHARMACY		DATE		PLACE		CITY		STATE	
SIGNATURE OF LABORATORY		DATE		PLACE		CITY		STATE	
SIGNATURE OF RADIOLOGY		DATE		PLACE		CITY		STATE	
SIGNATURE OF PATHOLOGY		DATE		PLACE		CITY		STATE	
SIGNATURE OF ANATOMY		DATE		PLACE		CITY		STATE	
SIGNATURE OF PHYSIOLOGY		DATE		PLACE		CITY		STATE	
SIGNATURE OF BIOLOGY		DATE		PLACE		CITY		STATE	
SIGNATURE OF CHEMISTRY		DATE		PLACE		CITY		STATE	
SIGNATURE OF PHYSICS		DATE		PLACE		CITY		STATE	
SIGNATURE OF MATHEMATICS		DATE		PLACE		CITY		STATE	
SIGNATURE OF ASTRONOMY		DATE		PLACE		CITY		STATE	
SIGNATURE OF METEOROLOGY		DATE		PLACE		CITY		STATE	
SIGNATURE OF CLIMATE		DATE		PLACE		CITY		STATE	
SIGNATURE OF WEATHER		DATE		PLACE		CITY		STATE	
SIGNATURE OF ENVIRONMENT		DATE		PLACE		CITY		STATE	
SIGNATURE OF GEOGRAPHY		DATE		PLACE		CITY		STATE	
SIGNATURE OF HISTORY		DATE		PLACE		CITY		STATE	
SIGNATURE OF LITERATURE		DATE		PLACE		CITY		STATE	
SIGNATURE OF ARTS		DATE		PLACE		CITY		STATE	
SIGNATURE OF MUSIC		DATE		PLACE		CITY		STATE	
SIGNATURE OF THEATRE		DATE		PLACE		CITY		STATE	
SIGNATURE OF FILM		DATE		PLACE		CITY		STATE	
SIGNATURE OF TELEVISION		DATE		PLACE		CITY		STATE	
SIGNATURE OF RADIO		DATE		PLACE		CITY		STATE	
SIGNATURE OF COMUNICATIONS		DATE		PLACE		CITY		STATE	
SIGNATURE OF TRANSPORTATION		DATE		PLACE		CITY		STATE	
SIGNATURE OF INFRASTRUCTURE		DATE		PLACE		CITY		STATE	
SIGNATURE OF UTILITIES		DATE		PLACE		CITY		STATE	
SIGNATURE OF ENERGY		DATE		PLACE		CITY		STATE	
SIGNATURE OF ENVIRONMENTAL		DATE		PLACE		CITY		STATE	
SIGNATURE OF CONSERVATION		DATE		PLACE		CITY		STATE	
SIGNATURE OF RECREATION		DATE		PLACE		CITY		STATE	
SIGNATURE OF CULTURE		DATE		PLACE		CITY		STATE	
SIGNATURE OF SOCIETY		DATE		PLACE		CITY		STATE	
SIGNATURE OF COMMUNITY		DATE		PLACE		CITY		STATE	
SIGNATURE OF GOVERNMENT		DATE		PLACE		CITY		STATE	
SIGNATURE OF POLITICS		DATE		PLACE		CITY		STATE	
SIGNATURE OF ECONOMICS		DATE		PLACE		CITY		STATE	
SIGNATURE OF BUSINESS		DATE		PLACE		CITY		STATE	
SIGNATURE OF INDUSTRY		DATE		PLACE		CITY		STATE	
SIGNATURE OF AGRICULTURE		DATE		PLACE		CITY		STATE	
SIGNATURE OF FISHERY		DATE		PLACE		CITY		STATE	
SIGNATURE OF FORESTRY		DATE		PLACE		CITY		STATE	
SIGNATURE OF MINING		DATE		PLACE		CITY		STATE	
SIGNATURE OF CONSTRUCTION		DATE		PLACE		CITY		STATE	
SIGNATURE OF MANUFACTURING		DATE		PLACE		CITY		STATE	
SIGNATURE OF DISTRIBUTION		DATE		PLACE		CITY		STATE	
SIGNATURE OF RETAIL		DATE		PLACE		CITY		STATE	
SIGNATURE OF WHOLESALE		DATE		PLACE		CITY		STATE	
SIGNATURE OF TRADE		DATE		PLACE		CITY		STATE	
SIGNATURE OF COMMERCE		DATE		PLACE		CITY		STATE	
SIGNATURE OF FINANCE		DATE		PLACE		CITY		STATE	
SIGNATURE OF BANKING		DATE		PLACE		CITY		STATE	
SIGNATURE OF INSURANCE		DATE		PLACE		CITY		STATE	
SIGNATURE OF INVESTMENT		DATE		PLACE		CITY		STATE	
SIGNATURE OF SAVINGS		DATE		PLACE		CITY		STATE	
SIGNATURE OF CREDIT		DATE		PLACE		CITY		STATE	
SIGNATURE OF DEBT		DATE		PLACE		CITY		STATE	
SIGNATURE OF MONEY		DATE		PLACE		CITY		STATE	
SIGNATURE OF CURRENCY		DATE		PLACE		CITY		STATE	
SIGNATURE OF COIN		DATE		PLACE		CITY		STATE	
SIGNATURE OF PAPER		DATE		PLACE		CITY		STATE	
SIGNATURE OF METAL		DATE		PLACE		CITY		STATE	
SIGNATURE OF OIL		DATE		PLACE		CITY		STATE	
SIGNATURE OF GAS		DATE		PLACE		CITY		STATE	
SIGNATURE OF ELECTRICITY		DATE		PLACE		CITY		STATE	
SIGNATURE OF WATER		DATE		PLACE		CITY		STATE	
SIGNATURE OF SEWER		DATE		PLACE		CITY		STATE	
SIGNATURE OF WASTE		DATE		PLACE		CITY		STATE	
SIGNATURE OF POLLUTION		DATE		PLACE		CITY		STATE	
SIGNATURE OF CLEAN		DATE		PLACE		CITY		STATE	
SIGNATURE OF HEALTHY		DATE		PLACE		CITY		STATE	
SIGNATURE OF SAFE		DATE		PLACE		CITY		STATE	
SIGNATURE OF SOUND		DATE		PLACE		CITY		STATE	
SIGNATURE OF MENTAL		DATE		PLACE		CITY		STATE	
SIGNATURE OF PHYSICAL		DATE		PLACE		CITY		STATE	
SIGNATURE OF EMOTIONAL		DATE		PLACE		CITY		STATE	
SIGNATURE OF SOCIAL		DATE		PLACE		CITY		STATE	
SIGNATURE OF PERSONAL		DATE		PLACE		CITY		STATE	
SIGNATURE OF FAMILY		DATE		PLACE		CITY		STATE	
SIGNATURE OF COMMUNITY		DATE		PLACE		CITY		STATE	
SIGNATURE OF NATION		DATE		PLACE		CITY		STATE	
SIGNATURE OF WORLD		DATE		PLACE		CITY		STATE	
SIGNATURE OF UNIVERSE		DATE		PLACE		CITY		STATE	
SIGNATURE OF GOD		DATE		PLACE		CITY		STATE	
SIGNATURE OF SPIRIT		DATE		PLACE		CITY		STATE	
SIGNATURE OF SOUL		DATE		PLACE		CITY		STATE	
SIGNATURE OF BODY		DATE		PLACE		CITY		STATE	
SIGNATURE OF MIND		DATE		PLACE		CITY		STATE	
SIGNATURE OF HEART		DATE		PLACE		CITY		STATE	
SIGNATURE OF LUNGS		DATE		PLACE		CITY		STATE	
SIGNATURE OF LIVER		DATE		PLACE		CITY		STATE	
SIGNATURE OF STOMACH		DATE		PLACE		CITY		STATE	
SIGNATURE OF PANCREAS		DATE		PLACE		CITY		STATE	
SIGNATURE OF SPLEEN		DATE		PLACE		CITY		STATE	
SIGNATURE OF KIDNEY		DATE		PLACE		CITY		STATE	
SIGNATURE OF BLADDER		DATE		PLACE		CITY		STATE	
SIGNATURE OF UTERUS		DATE		PLACE		CITY		STATE	
SIGNATURE OF VAGINA		DATE		PLACE		CITY		STATE	
SIGNATURE OF PENIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF TESTIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF OVARY		DATE		PLACE		CITY		STATE	
SIGNATURE OF UTERUS		DATE		PLACE		CITY		STATE	
SIGNATURE OF VAGINA		DATE		PLACE		CITY		STATE	
SIGNATURE OF PENIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF TESTIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF OVARY		DATE		PLACE		CITY		STATE	
SIGNATURE OF UTERUS		DATE		PLACE		CITY		STATE	
SIGNATURE OF VAGINA		DATE		PLACE		CITY		STATE	
SIGNATURE OF PENIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF TESTIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF OVARY		DATE		PLACE		CITY		STATE	
SIGNATURE OF UTERUS		DATE		PLACE		CITY		STATE	
SIGNATURE OF VAGINA		DATE		PLACE		CITY		STATE	
SIGNATURE OF PENIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF TESTIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF OVARY		DATE		PLACE		CITY		STATE	
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SIGNATURE OF TESTIS		DATE		PLACE		CITY		STATE	
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SIGNATURE OF TESTIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF OVARY		DATE		PLACE		CITY		STATE	
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SIGNATURE OF VAGINA		DATE		PLACE		CITY		STATE	
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SIGNATURE OF OVARY		DATE		PLACE		CITY		STATE	
SIGNATURE OF UTERUS		DATE		PLACE		CITY		STATE	
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SIGNATURE OF TESTIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF OVARY		DATE		PLACE		CITY		STATE	
SIGNATURE OF UTERUS		DATE		PLACE		CITY		STATE	
SIGNATURE OF VAGINA		DATE		PLACE		CITY		STATE	
SIGNATURE OF PENIS		DATE		PLACE		CITY		STATE	
SIGNATURE OF TESTIS		DATE		PLACE		CITY		STATE</	

12877

Reg. Dist. No.

12969

1. PLACE OF BIRTH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 65 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William First R Middle Buck Last		4. DATE OF DEATH November 19, 1960 Month XXXXXXXXXX Day 19 Year 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 14, 1877	
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Oper. Own Business		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Buck		14. MOTHER'S MAIDEN NAME Susan Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Martin Eugene Buck Address 1406 S Street, S.E. Washington 20, D.C.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic CV Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 mo 10 yrs		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 59 , to 19 Nov , 19 60 , that I last saw the deceased alive on 18 Nov , 19 60 , and that death occurred at 3:04 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Upper Marlboro, Md. DATE SIGNED 11/19/60		22. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.-Upper Marlboro, Md. ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 28 '60	
24b. REGISTRAR'S SIGNATURE Carlton S. S.		25. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

12889
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

12878

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor, 4922 LaSalle Rd</u>		d. STREET ADDRESS <u>2904 Naylor Rd. S.E</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mrs Clara</u> Middle <u>H</u> Last <u>Burby</u>		4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/80</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse (undergraduate)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Charleston, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes - U.S.A.</u>	
13. FATHER'S NAME <u>James H. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-48-0760</u>	
INFORMANT <u>Dr. M. Davis Catherine</u> Address <u>4922 LaSalle Pl. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Congestive Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>ASPD and Metastatic CA</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5</u> , 19 <u>54</u> , to <u>11/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/18</u> , 19 <u>60</u> , and that death occurred at <u>8:32 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David L. Leary</u> M.D.		ADDRESS (Street, city or town, state) <u>2901 Fairview SE 11/18/60</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>David L. Leary</u>		<u>H. West Mayhew, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 22, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Walters</u> ADDRESS <u>254 Carroll St NW. DC</u>		24. REC'D BY REGISTRAR <u>Charles E. Fenn</u> DATE <u>NOV 21 '60</u>	

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Items 7, 8, 9, 11, 13, 14 Film G276 12-9-60 et									
1. PLACE OF DEATH a. COUNTY Prince Georges County		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Florida		b. COUNTY unknown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1299 NW 23rd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WESTLEY		4. DATE OF DEATH November 19, 1960.							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown		8. DATE OF BIRTH June 27, 1899		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Myron William Cartee				14. MOTHER'S MAIDEN NAME Laura Dell Riechfirce(?)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Artery Disease (a), stating the underlying cause last. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		DATE SIGNED November 19, 1960.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-28-60 U. of Md. Med. School		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Baltimore Md.		22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR NOV 29 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

12879

18903

Unknown

Florida

Prince George County

Jacksonville

Georgia

Prince George General Hospital 1892 NW 23rd Street

November 18, 1900

WHITE

WESTLEY

Male

U.S.A.



Coronary Heart Failure
Coronary Artery Disease

X

X

X

X

JAMES I. BOYD, M.D.

November 18, 1900

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>						c. LENGTH OF STAY IN 1b <u>200</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>						e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					
3. NAME OF DECEASED (Type or print) <u>Bessie Kay Carter</u>						4. DATE OF DEATH <u>Nov 10 1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-31</u>		9. AGE (in years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. FATHER'S NAME <u>Bryant Bell</u>						14. MOTHER'S MAIDEN NAME <u>Ardell Sowell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>same as #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> DUE TO (b) <u>Gun shot wound of abdomen</u> DUE TO (c) <u>Gun shot wound of abdomen</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot during an altercation</u>					
20c. TIME OF INJURY Month, Day, Year <u>5 a.m. 11/10/60</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Suburban North Brentwood B.M.</u>						20f. (City or town) (County) (State) <u>North Brentwood B.M.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>James I. Boyd</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) <u>11/11/60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-20-60</u>				22b. DATE THEREOF <u>11-20-60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>York Rd Cemetery</u>			
								22d. LOCATION (City, town, or country) (State) <u>Charlotte, N.C.</u>			
23. FUNERAL DIRECTOR <u>R.L. Crouch</u> ADDRESS <u>51 Kay St. N.W.</u>						24a. REC'D BY REGISTRAR <u>NOV 21 '60</u>					
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>					

MEDICAL CERTIFICATION

WESTERN LIFE ASSURANCE COMPANY OF NEW YORK
12304 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE LAW
1910
(M)

[Faint, mostly illegible handwritten text, likely a medical report or certificate. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

!

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

(M)

MEDICAL CERTIFICATION

1. PLACE OF DEATH e. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>										2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u> d. STREET ADDRESS <u>12513 Gaither Street</u>														
3. NAME OF DECEASED (Type or print) <u>Elizabeth Florene Casey</u>										4. DATE OF DEATH <u>Nov 17 1960</u>														
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 14 1923</u>				9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>					11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>					12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>									
13. FATHER'S NAME <u>William Joseph Casey</u>					14. MOTHER'S MAIDEN NAME <u>Emma F Copfield</u>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>578-22-0415</u>					17. INFORMANT <u>Beth Artfack</u>					Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Extensive osteoarthritis</u>															INTERVAL BETWEEN ONSET AND DEATH									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																								
ACTUAL SIGNATURE <u>James I. Boyd</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>11-17-60</u>				
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>					Address (Street, city, town, or county)																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Nov 19-60</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Becker Hill Cemetery</u>					22d. LOCATION (City, town, or country) (State) <u>Smithland Md</u>									
23. FUNERAL DIRECTOR <u>Summers Bros</u>					ADDRESS <u>1661 - gd Hope Rd</u>					24a. REC'D BY REGISTRAR <u>Nov 21 '60</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>									

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12905 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3, 13, 14 Film G277 12-22-60 et

Reg. Dist. No. 12882

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>Waldo</u> Middle <u>Washington</u> Last <u>COLLINS</u>				4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 Feb 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Wesley Collins</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Hurtle</u> Hurdle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>579-28-6321</u>			
17. INFORMANT Address <u>Mrs Ethel Brown (Dau) Same as # 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>inst.</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis Heart disease</u> <u>years</u> DUE TO (c) <u>Generalized Arterio Sclerosis</u> <u>years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>No</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-29-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Addison's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington, D.C.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.
(M)

MEDICAL CERTIFICATION

12971												12883											
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY None											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ardmore												c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington											
c. LENGTH OF STAY IN lb Found												d. STREET ADDRESS 2415 14th Street N. E.											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) In wooded area.												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MICHAEL JOSEPH CONDETTI												4. DATE OF DEATH November 17, 1960.											
5. SEX Male												6. COLOR OR RACE White											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH Jan. 10, 1953											
9. AGE (In years last birthday) 7 yrs. 10 Months 7 Days												10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child												10b. KIND OF BUSINESS OR INDUSTRY School											
11. BIRTHPLACE (State or foreign country) Montgomery County												12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Augustine Joseph Condetti												14. MOTHER'S MAIDEN NAME Joan Smithers											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No												16. SOCIAL SECURITY NO. None											
17. INFORMANT Mr. Augustine J. Condetti, Wash., D.C.												Address 2415 14th St., NE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Suffocation DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) Seduced and Criminally Assaulted.											
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. 19												20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Undetermined												20f. (City or town) (County) (State) Undetermined											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE James I. Boyd M.D.												CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												DATE SIGNED November 18, 1960.											
Address (Street, city, town, or county)																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial												22b. DATE THEREOF 11/21/60											
22c. NAME OF CEMETERY OR CREMATORY Arlington National												22d. LOCATION (City, town, or country) (State) Arlington, Va.											
23. FUNERAL DIRECTOR NALLEY'S FUNERAL HOME, Island Ave., N.E.												24a. REC'D BY REGISTRAR NOV 28 '60											
24b. REGISTRAR'S SIGNATURE Arthur S. Hume																							

Mt. Rainier, Md

Trinity College

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Augustine Joseph Gonsky

John B. J. J. J.

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Mr. Augustine J. Conzatti, Wash., D.C.

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Unbestätigt - Brief Konfirmations X

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JAMES I. BOYD, M.D.

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November 18, 1960

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12972
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12884

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b 6- Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				d. STREET ADDRESS 2124- Minn., Ave., S.E. 47X-		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle Last DATTORE				4. DATE OF DEATH Month Nov. Day 7th Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3rd. 1883	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Iron Worker		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Borsilo Dattore				14. MOTHER'S MAIDEN NAME Rosina Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Frank V. Dattore 5951- 28th Ave./, S.E. Marlow Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cerebral thrombosis DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 15 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 10, 1960, to Nov 6, 1960, that (I) (we) last saw the deceased alive on 11-6-1960, and that death occurred at 7:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Cleary				22b. DATE SIGNED Nov. 7th 1960			
22c. PHYSICIAN'S NAME (Type) Dr. Thomas F. Cleary				22d. ADDRESS 5556 Silver Hill Rd. SE District Hghts Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 9 -1960		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION (City, town, or county) Washington, D.C.				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				ADDRESS 1661- Good Hope Rd. S.E. Washington, D.C.		25a. REC'D BY REGISTRAR DATE NOV 8 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MEDICAL CERTIFICATION

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1992-1993 1993-1994 1994-1995 1995-1996 1996-1997 1997-1998 1998-1999 1999-2000 2000-2001 2001-2002 2002-2003 2003-2004 2004-2005 2005-2006 2006-2007 2007-2008 2008-2009 2009-2010 2010-2011 2011-2012 2012-2013 2013-2014 2014-2015 2015-2016 2016-2017 2017-2018 2018-2019 2019-2020 2020-2021 2021-2022 2022-2023 2023-2024 2024-2025 2025-2026 2026-2027 2027-2028 2028-2029 2029-2030 2030-2031 2031-2032 2032-2033 2033-2034 2034-2035 2035-2036 2036-2037 2037-2038 2038-2039 2039-2040 2040-2041 2041-2042 2042-2043 2043-2044 2044-2045 2045-2046 2046-2047 2047-2048 2048-2049 2049-2050 2050-2051 2051-2052 2052-2053 2053-2054 2054-2055 2055-2056 2056-2057 2057-2058 2058-2059 2059-2060 2060-2061 2061-2062 2062-2063 2063-2064 2064-2065 2065-2066 2066-2067 2067-2068 2068-2069 2069-2070 2070-2071 2071-2072 2072-2073 2073-2074 2074-2075 2075-2076 2076-2077 2077-2078 2078-2079 2079-2080 2080-2081 2081-2082 2082-2083 2083-2084 2084-2085 2085-2086 2086-2087 2087-2088 2088-2089 2089-2090 2090-2091 2091-2092 2092-2093 2093-2094 2094-2095 2095-2096 2096-2097 2097-2098 2098-2099 2099-2100 2100-2101 2101-2102 2102-2103 2103-2104 2104-2105 2105-2106 2106-2107 2107-2108 2108-2109 2109-2110 2110-2111 2111-2112 2112-2113 2113-2114 2114-2115 2115-2116 2116-2117 2117-2118 2118-2119 2119-2120 2120-2121 2121-2122 2122-2123 2123-2124 2124-2125 2125-2126 2126-2127 2127-2128 2128-2129 2129-2130 2130-2131 2131-2132 2132-2133 2133-2134 2134-2135 2135-2136 2136-2137 2137-2138 2138-2139 2139-2140 2140-2141 2141-2142 2142-2143 2143-2144 2144-2145 2145-2146 2146-2147 2147-2148 2148-2149 2149-2150 2150-2151 2151-2152 2152-2153 2153-2154 2154-2155 2155-2156 2156-2157 2157-2158 2158-2159 2159-2160 2160-2161 2161-2162 2162-2163 2163-2164 2164-2165 2165-2166 2166-2167 2167-2168 2168-2169 2169-2170 2170-2171 2171-2172 2172-2173 2173-2174 2174-2175 2175-2176 2176-2177 2177-2178 2178-2179 2179-2180 2180-2181 2181-2182 2182-2183 2183-2184 2184-2185 2185-2186 2186-2187 2187-2188 2188-2189 2189-2190 2190-2191 2191-2192 2192-2193 2193-2194 2194-2195 2195-2196 2196-2197 2197-2198 2198-2199 2199-2200 2200-2201 2201-2202 2202-2203 2203-2204 2204-2205 2205-2206 2206-2207 2207-2208 2208-2209 2209-2210 2210-2211 2211-2212 2212-2213 2213-2214 2214-2215 2215-2216 2216-2217 2217-2218 2218-2219 2219-2220 2220-2221 2221-2222 2222-2223 2223-2224 2224-2225 2225-2226 2226-2227 2227-2228 2228-2229 2229-2230 2230-2231 2231-2232 2232-2233 2233-2234 2234-2235 2235-2236 2236-2237 2237-2238 2238-2239 2239-2240 2240-2241 2241-2242 2242-2243 2243-2244 2244-2245 2245-2246 2246-2247 2247-2248 2248-2249 2249-2250 2250-2251 2251-2252 2252-2253 2253-2254 2254-2255 2255-2256 2256-2257 2257-2258 2258-2259 2259-2260 2260-2261 2261-2262 2262-2263 2263-2264 2264-2265 2265-2266 2266-2267 2267-2268 2268-2269 2269-2270 2270-2271 2271-2272 2272-2273 2273-2274 2274-2275 2275-2276 2276-2277 2277-2278 2278-2279 2279-2280 2280-2281 2281-2282 2282-2283 2283-2284 2284-2285 2285-2286 2286-2287 2287-2288 2288-2289 2289-2290 2290-2291 2291-2292 2292-2293 2293-2294 2294-2295 2295-2296 2296-2297 2297-2298 2298-2299 2299-2300 2300-2301 2301-2302 2302-2303 2303-2304 2304-2305 2305-2306 2306-2307 2307-2308 2308-2309 2309-2310 2310-2311 2311-2312 2312-2313 2313-2314 2314-2315 2315-2316 2316-2317 2317-2318 2318-2319 2319-2320 2320-2321 2321-2322 2322-2323 2323-2324 2324-2325 2325-2326 2326-2327 2327-2328 2328-2329 2329-2330 2330-2331 2331-2332 2332-2333 2333-2334 2334-2335 2335-2336 2336-2337 2337-2338 2338-2339 2339-2340 2340-2341 2341-2342 2342-2343 2343-2344 2344-2345 2345-2346 2346-2347 2347-2348 2348-2349 2349-2350 2350-2351 2351-2352 2352-2353 2353-2354 2354-2355 2355-2356 2356-2357 2357-2358 2358-2359 2359-2360 2360-2361 2361-2362 2362-2363 2363-2364 2364-2365 2365-2366 2366-2367 2367-2368 2368-2369 2369-2370 2370-2371 2371-2372 2372-2373 2373-2374 2374-2375 2375-2376 2376-2377 2377-2378 2378-2379 2379-2380 2380-2381 2381-2382 2382-2383 2383-2384 2384-2385 2385-2386 2386-2387 2387-2388 2388-2389 2389-2390 2390-2391 2391-2392 2392-2393 2393-2394 2394-2395 2395-2396 2396-2397 2397-2398 2398-2399 2399-2400 2400-2401 2401-2

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose 14 certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12885

12906

Items 3, 17 Film G279 1-13-61 et

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 231 9th Street West	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Annie Annie Florence Day		4. DATE OF DEATH Month Day Year Nov. 22, 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1892	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Warren Phelps		14. MOTHER'S MAIDEN NAME Capitola Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT 1006 Maple Ave. Bowie, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure few minutes 420 - 0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease 2 1/2 years (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Generalized 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. no 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE Dayton O Watkins M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DAYTON O WATKINS ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11-22-60 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11/25/60 22c. NAME OF CEMETERY OR CREMATORY Holy Trinity 22d. LOCATION (City, town, or county) (State) Collington Md. 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md. 24a. REC'D BY REGISTRAR DATE NOV 28 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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CERTIFICATE OF DEATH

12886

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor		d. STREET ADDRESS 4922 La Salle Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last NELLE S. DEAN		4. DATE OF DEATH Month 11 Day 25 Year 1960	
5. SEX Fem	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/88
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Shiles		14. MOTHER'S MAIDEN NAME Sarty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Jane Dean		Address 223 W. Montgomery Ave. Rockville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebro Vascular Occlusion (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1954 to 11/25, 1960, that (I) (we) last saw the deceased alive on 11/25, 1960 and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Adolph H. Friedman M.D.		22b. DATE SIGNED 11/25/60	
22c. PHYSICIAN'S NAME (Type) ADOLPH H. FRIEDMAN		22d. ADDRESS 900-17th St. NW Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/60	
23c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery		23d. LOCATION (City, town, or county) (State) Berryville, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		25. REC'D BY REGISTRAR DATE NOV 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. House			

CERTIFICATE OF DEATH

1880

Barroville, Virginia

County of Barroville

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Barroville, Virginia

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 42	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>				d. STREET ADDRESS <u>3908-53 PL 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susan B DeRooy</u>				4. DATE OF DEATH: <u>Nov 8 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25 1889</u> 71 yrs.	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>James Edward Fopscott</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Barbara Frohman</u> Address <u>allison St London Hill</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerotic heart</u> DUE TO <u>disease</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 1 hour</u> <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>no</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <u>—</u>			
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>				22e. REC'D BY REGISTRAR <u>—</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>				23a. ADDRESS <u>3260-R, 1st Ave Mt. Rainier, Md.</u>		23b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Dayton O Watkins M.D.
DAYTON O. WATKINS

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

11-9-60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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2. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No. 12888

12908

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Pr Geo</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i> 42	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges General</i>		d. STREET ADDRESS <i>2812 Laurel ave</i>	
3. NAME OF DECEASED (Type or print) <i>Urban</i> First <i>J</i> Middle <i>Dowling</i> Last		4. DATE OF DEATH Month <i>11</i> Day <i>26</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 12, 1912</i>
9. AGE (In years lost birthday) <i>48</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Physician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Physician</i>	
11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>James Dowling</i>		14. MOTHER'S MAIDEN NAME <i>? Hertel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Leona Dowling</i> Address <i>Cheverly Md.</i>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>Nov 26, 1960</i> to <i>Nov 26, 1960</i> that I last saw the deceased alive on <i>Nov 26, 1960</i> and that death occurred at <i>1:50 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dayton Watkins</i>		ADDRESS (Street, city or town, state) <i>5304 Annapolis Rd</i> DATE SIGNED <i>11-27-60</i>	
PHYSICIAN'S NAME (Type) <i>DAYTON O WATKINS</i> <i>Bladensburg Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 28, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Rockville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 29 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12956
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12889

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Mem. Hospital</u>				d. STREET ADDRESS <u>112030 Gunpowder Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ellen Dunagin</u>				4. DATE OF DEATH Month Day Year <u>Nov. 25 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/1/78</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Russell Gossett</u>				14. MOTHER'S MAIDEN NAME <u>Jane Kirby Gossett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Daughter Same as</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO INJURY</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>Nov 25, 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 25, 1960</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>R. H. Sandstrom</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-25-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom M.D.</u>				22d. ADDRESS <u>10202 Lariston Lane, Silver</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Nov 28, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Memorial Garden</u>		23d. LOCATION (City, town, or county) (State) <u>SPARTANBURG N. CAR</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u>				ADDRESS <u>254 Carroll St NW D.C.</u>		25a. RECEIVED BY REGISTRAR DATE <u>Nov 28 1960</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

12345



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12890

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4816 48th Ave.				e. STREET ADDRESS 4816 48th Ave.			
3. NAME OF DECEASED (Type or print) First Alice Middle Bell Last Dunn				4. DATE OF DEATH Month November Day 18 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 22, 1889	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 11 Hours 15 Min.		IF UNDER 24 HRS. Months 7 Days 11 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Clatterbuok				14. MOTHER'S MAIDEN NAME Sarah ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Benjamin F. Dunn 4816 48 Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cute Coronary Thrombosis. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease. DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m. Month 11 Day 18 Year 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4314 GALLATIN ST.	
20f. (City or town) HYATTSVILLE, MD.				20g. (County) PRINCE GEORGES			
20h. (State) MARYLAND							
21. I certify that I attended the deceased from 9-26-1960 to 11-18-1960 that I last saw the deceased alive on 10-31-1960 , and that death occurred on 11-18-1960 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) 4314 GALLATIN ST., HYATTSVILLE, MD.			
DATE SIGNED 11/18/60							
PHYSICIAN'S NAME (Type) Dr. Aaron Deitz, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE NOV 23 '60	
24b. REGISTRAR'S SIGNATURE [Signature]							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

12345

DECEASED Prince George		PLACE OF BIRTH Maryland	
DATE OF BIRTH November 1, 1899		PLACE OF DEATH Baltimore, Maryland	
SEX Male		RACE White	
OCCUPATION None		CAUSE OF DEATH Heart Disease	
DATE OF DEATH October 22, 1932		PLACE OF INTERMENT St. James	
NAME OF DECEASED John Christopher		PLACE OF BIRTH Baltimore, Maryland	
DATE OF BIRTH November 1, 1899		PLACE OF DEATH Baltimore, Maryland	
SEX Male		RACE White	
OCCUPATION None		CAUSE OF DEATH Heart Disease	
DATE OF DEATH October 22, 1932		PLACE OF INTERMENT St. James	
NAME OF DECEASED Benjamin F. Dunn		PLACE OF BIRTH Baltimore, Maryland	
DATE OF BIRTH November 1, 1899		PLACE OF DEATH Baltimore, Maryland	
SEX Male		RACE White	
OCCUPATION None		CAUSE OF DEATH Heart Disease	
DATE OF DEATH October 22, 1932		PLACE OF INTERMENT St. James	

This certificate is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 22nd day of October, 1932.
 W. T. CHANDLER, CO., BALTIMORE, MD.
 12/22/32
 Baltimore, Maryland

12952

CERTIFICATE OF DEATH

Reg. Dist. No.

12891

1. PLACE OF DEATH o. COUNTY <i>Prince George County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Illinois</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Evanston</i> 51x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Furling Apts - Main Street</i>		d. STREET ADDRESS <i>827 Brummel Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Leah</i> First <i>Estrin</i> Middle Last		4. DATE OF DEATH <i>Nov 3</i> Month Day Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Alex Estrin - Furling Apts - Main St</i> Address <i>Laurel Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> DUE TO <i>260X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerosis</i> DUE TO (c) <i>Diabetes mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>90 min.</i> <i>104p.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/11</i> , 1960, to <i>11/3</i> , 1960, that I last saw the deceased alive on <i>11/3</i> , 1960, and that death occurred at <i>4 A</i> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul V. Weaver, Jr.</i>		ADDRESS (Street, city or town, state) <i>320 Montgomery St., Laurel, Md</i>	
PHYSICIAN'S NAME (Type) <i>Dr. S. J. Weaver, Jr.</i>		DATE SIGNED <i>11/3/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov-3/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Westlawn Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Chicago, Illinois</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sold Lennear & Sons</i> ADDRESS <i>6010 Reist Road</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 7 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews		d. STREET ADDRESS 1413 Cavlier Corridor	
3. NAME OF DECEASED (Type or print) First Middle Last Mattie B Frazier		4. DATE OF DEATH Month Day Year November 8 19 60	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 SEP 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESLADY		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME R RUBEN WALK		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT COL BRADLEY, 1413 CAVLIER CORR.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.9 Bronchopneumonia, terminal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Glioblastoma Multiformae (c) INTERVAL BETWEEN ONSET AND DEATH 48 hours 6 months		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 8 November 19 60, and that death occurred at 4:50 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Bittick Jr. M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Paul Bittick Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-12-60	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Blackwell Oklahoma
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ronaldi Funeral Home, 816-H St. NE		24a. REC'D BY REGISTRAR DATE NOV 10 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

CERTIFICATE OF DEATH

12000

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12909											
12893											
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE D. C. b. COUNTY None					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 1909 P Street S. E.					
3. NAME OF DECEASED (Type or print) GERMAINE CATHERINE FREDERICK						4. DATE OF DEATH Month November Day 22 , Year 1960 .					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1903		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Reuter						14. MOTHER'S MAIDEN NAME Jennie Cain					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None						16. SOCIAL SECURITY NO. unknown					
17. INFORMANT Louis P. Frederick						Address 1909 P St., S.E. Washington, D. C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension Heart Disease DUE TO (c) 420.1											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						DATE SIGNED November 22, 1960.					
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-25-1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Suitland Md				22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR Mattingly				ADDRESS 131-11 St Wash DC				24a. REC'D BY REGISTRAR NOV 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. King	

FOR THE
DEPARTMENT OF
THE ARMY
1914

Prince Georges County
Washington
November 22, 1900
July 10, 1903
Female
White
U.S. Govt.
Washington, D.C.
John C. Renter
None
Louis P. Frederick
Washington, D.C.
November 22, 1900
Hypertension Heart Disease
Gonorrhea Oculitis

JAMES I. BOYD, M.D.
November 22, 1900
NATIONAL BUREAU OF HEALTH

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12894

12910 Items 10, 11, 12, 13, 14 Film G276 12-6-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) o. STATE <u>And</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	c. LENGTH OF STAY IN 1b <u>5 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>2512 Von Buren St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADELLE GAVENKORT</u>		4. DATE OF DEATH Month Day Year <u>Nov 22 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 8 1987</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Box Factory</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Anthony Gavenkort (sic)</u>		14. MOTHER'S MAIDEN NAME <u>Frances (Last name unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-9454</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adrenal insufficiency</u> DUE TO <u>Ca fluid of Pancreas</u> (c) <u>metastasis to adrenal glands + liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>not</u> <u>Weeks</u> <u>Weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>metastasis to adrenal glands + liver</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>11/28/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Etchedraf</u>		22d. LOCATION (City, town, or county) (State) <u>Balt Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Howell</u>		ADDRESS <u>Pileville, Md</u>	
24a. REC'D BY REGISTRAR <u>Nov 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chertsey		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 32 - 17 th Street SE	
3. NAME OF DECEASED (Type or print) Lester Albert Gaynor		4. DATE OF DEATH Nov 11 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 29, 1923
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative County DC Govt		11. BIRTHPLACE (State or foreign country) District Columbia U.S.	
13. FATHER'S NAME Leroy Gaynor		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO. 17. INFORMANT Joyce Gaynor, same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion Conditions, if any, which gave rise to immediate cause (b) Coronary atherosclerosis (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED 11-11-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or country) (State) Fort Meyer, Virginia	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
Regina's Fun Home, Inc, 389 Rhode Island Ave, N.W.		DATE NOV 16 '60	
Washington, D.C.		C. L. K. K. K.	

Form with multiple sections for recording death information, including fields for name, age, sex, cause of death, and place of death. The form is mostly blank, with some faint handwriting visible in the lower right section.

Handwritten signature and text at the bottom right of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12912

12896

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Mt. Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		d. STREET ADDRESS 14113 Rainier Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lillian -Green- May		4. DATE OF DEATH 11-10-60	
First Lillian Middle -Green- Last May		Month 11 Day 10 Year 1960	
5. SEX Fe.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-82
9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	10. BIRTHPLACE (State or foreign country) Washington, D.C.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John P. Baker		14. MOTHER'S MAIDEN NAME Catherine Whithead	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 216-12-4314	
17. INFORMANT Daughter		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction- left Ventricle DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to 11/10 19 60 , that (I) (we) last saw the deceased alive on 11/9 19 60 , and that death occurred at 12:54 M. from the causes and on the date stated above.			
22a. SIGNATURE Leon R. Levitsky M.D.		22b. DATE SIGNED 11/10/60	
22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky		22d. ADDRESS 3408 Rhode Island Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Mt. Rainier, Inc.		25. REGISTRAR'S SIGNATURE Arthur S. Kraus	
ADDRESS Mt. Rainier, Md.		26. REC'D BY REGISTRAR NOV 14 '60	

15913

CERTIFICATE OF DEATH

MAINTAIN THE INTEGRITY OF HEALTH
NOT A VARIOUS HEALTH RECORD - IN THE DEPT. OF HEALTH

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan. Some visible text includes "Name", "Date", and "Place".

1.
FOR STATE
HEALTH DEPT.

TO DEFEND MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12897

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs. d. STREET ADDRESS 5202 Stanhaven Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY AGNES GREEN			4. DATE OF DEATH November 13, 1960.		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1890		9. AGE (in years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? yes.			13. FATHER'S NAME James Sullivan		
14. MOTHER'S MAIDEN NAME Mary Shahan			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		
16. SOCIAL SECURITY NO. 577-38-1748			17. INFORMANT Thomas F. Wert, Jr.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11-17-60		
22c. NAME OF CEMETERY OR CREMATORY Arlington National			22d. LOCATION (City, town, or country) (State) Arlington, Va.		
23. FUNERAL DIRECTOR James T. Ryan, Inc.			24a. REC'D BY REGISTRAR NOV 16 '60		
24b. REGISTRAR'S SIGNATURE James I. Boyd, M. D.			24c. DATE SIGNED November 14, 1960.		



12013

Prince George

Overly

I.O.A.

Camp Springs

Prince George's

Prince George General Hospital 2502 Stevenson Rd.

MARY

JOHN

GREEN

November 15

60.

Female

White

X

Sept. 12, 1890 70

Gray

U.S. Gov't

Washington, D.C.

Yes.

James Sullivan

Kerry Shannon

no

70-1-10 Thomas E. West, Jr. Wash. D.C.

2502 Stevenson Rd. Wash. D.C.

JAMES I. FORD, M. D.

November 15, 1900

12974

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pri. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1417 Madison Street				e. STREET ADDRESS 1417 Madison Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Iola Middle Griffiths Last Griffiths				4. DATE OF DEATH Month November Day 18, Year 19 60-			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 25, 1883		9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Peacock				14. MOTHER'S MAIDEN NAME Elizabeth Kirby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577 10 0150		INFORMANT Address Thelma Peacock West Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO ? (c) YEARS							INTERVAL BETWEEN ONSET AND DEATH 2 MIN.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 19 56 , to PRESENT , 19 60 , that I last saw the deceased alive on 14 Nov , 19 60 , and that death occurred at 9:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry R. Wolfe M.D.				ADDRESS (Street, city or town, state) 905 SHERIDAN ST.		DATE SIGNED 11/18/60	
PHYSICIAN'S NAME (Type) Henry R Wolfe				University Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 22, 1960		22c. NAME OF CEMETERY OR CHURCH George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR NOV 22 60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12024

CERTIFICATE OF DEATH

Name of deceased		John H. H. H. H.	
Age		45	
Sex		Male	
Race		White	
Marital status		Single	
Occupation		Farmer	
Cause of death		Heart disease	
Date of death		Nov. 10, 1950	
Place of death		Home	
Signature of physician		J. H. H. H.	
Signature of registrar		J. H. H. H.	
Signature of informant		J. H. H. H.	

Name of informant		John H. H. H.	
Address		1234 Main St., Hartsville, Md.	
Signature of informant		J. H. H. H.	
Signature of registrar		J. H. H. H.	
Signature of physician		J. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12914

12899

1

M

077

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 64 University Park			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Lillian B Gruber				4. DATE OF DEATH Month Day Year Nov. 11 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/6/84	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Burley				14. MOTHER'S MAIDEN NAME Emily ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Wilburt Lee Price Arlington Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, posterior 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion DUE TO (c) Coronary arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1946 to Nov 11, 1960, that (I) (we) last saw the deceased alive on Nov 10 1960, and that death occurred at 7:55 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Louis Mendel				22b. DATE 11/11/60		22c. PHYSICIAN'S NAME (Type) Dr. Louis Mendel	
22d. ADDRESS 4506 College Ave. Collage Park, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/60		23c. NAME OF CEMETERY OR CREMATORY Rock Creek		23d. LOCATION (City, town, or county) (State) Washington D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Maschi's Funeral Home				ADDRESS Hyattsville, Md		25a. REC'D BY REGISTRAR DATE NOV 16 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. House							

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

1901

IN SENATE

JANUARY 10, 1901

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

1900

ALBANY

1901

PRINTED BY

THE STATE

PRINTING OFFICE

ALBANY

NEW YORK: THE STATE PRINTING OFFICE, 1901.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12900**

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.				d. STREET ADDRESS 4011 Forest Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle GUTHRIE Last GUTHRIE				4. DATE OF DEATH Month Nov. Day 29 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Sept 1910	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Indiana			
13. FATHER'S NAME Truman Guthrie				14. MOTHER'S MAIDEN NAME Mable Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Magdelene Guthrie Address (Wife) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiphase lacerations Liver, Ribs DUE TO Pentonic Hemorrhage, Multiple 3 days DUE TO Rib fractures, Rt Hemithorax (Trauma) (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Calcific aortic stenosis secondary to Rheumatism Heart disease							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident					
20c. TIME OF INJURY Hour 11 a. m. 30 p. m. Month, Day, Year 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street			
20f. (City or town) St Paul		20f. (County) Indiana		20f. (State) Indiana			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Dayton O Wattenis				DATE SIGNED 11-29-60			
EXAMINER'S NAME (Type) DAYTON O WATTENIS				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 11/30/60		22c. NAME OF CEMETERY OR CREMATORY St Paul			
22d. LOCATION (City, town, or county) Indiana		22d. LOCATION (State) Indiana					
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.			
24a. REC'D BY REGISTRAR DEC 1 '60		24b. REGISTRAR'S SIGNATURE C. J. L. Smith					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No. 12891

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE, 620 SHERIDAN STREET</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>620 Sheridan Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>LAYELLE</u> Last <u>HALEY</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 25, 1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSELMOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EMPLOYMENT AGENCY</u>	
11. BIRTHPLACE (State or foreign country) <u>GEMON SOUTH DAKOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN E. HALEY</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE LAYELLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>MRS. JOHN ROQUEVERT 812 COX AVE. HYATTSVILLE</u>	
17. INFORMANT <u>MRS. JOHN ROQUEVERT</u>		Address <u>812 COX AVE. HYATTSVILLE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive heart disease</u> (c) <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Termed.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>60</u> , and that death occurred at <u>5:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Simpson</u> M.D.		ADDRESS (Street, city or town, state) <u>60216 N.H. Ave NE</u> DATE SIGNED <u>11/3/60</u>	
PHYSICIAN'S NAME (Type) <u>William F. Simpson</u>		<u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 9, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Name Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Rapids, Iowa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Walters</u>		ADDRESS <u>254 Carroll Rd NW DC</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Robert A. Walters</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12975

12902

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>East Riverdale</i> c. LENGTH OF STAY IN 1b <i>13 yrs</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>East Riverdale</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>D.O. Prince George General Hospital</i>				d. STREET ADDRESS <i>5710 63rd Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Norvine</i> Middle <i>Belle</i> Last <i>Hall</i>				4. DATE OF DEATH Month <i>11</i> Day <i>17</i> Year <i>1960</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 2 1909</i>		9. AGE (In years last birthday) <i>51 yrs.</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>15</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>							
13. FATHER'S NAME <i>George E. Boyer</i>				14. MOTHER'S MAIDEN NAME <i>Minnie</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>James M. Hall</i> Address <i>(HUSBAND)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i></i> DUE TO (c) <i></i>							INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Auricular Fibrillation</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i></i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 11-17-60</i> to <i>Present</i> , 19 <i>58</i> , that (I) (we) last saw the deceased alive on <i>11-17-60</i> , 19 <i>60</i> , and that death occurred at <i>11:45</i> AM, from the causes and on the date stated above.							
22a. SIGNATURE <i>William C. Weintraub</i>				22b. DATE SIGNED <i>11-17-60</i>			
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. WEINTRAUB, M.D.</i>				22d. ADDRESS <i>Greenbelt, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>Nov. 21, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co. Riverdale</i>				25a. REC'D BY REGISTRAR <i></i> DATE <i>NOV 21 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knaus</i>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12916 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12903

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>Week on annual</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> d. STREET ADDRESS <u>13019 - Park Way</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Hattie Elephanta Harris</u>		4. DATE OF DEATH <u>Nov 12 1960</u>		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1898</u>	
9. AGE (In years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTH PLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Frank George Pascoch</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Kirby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>James I. Boyd</u> ASSISTANT MEDICAL EXAMINER <u></u> DEPUTY MEDICAL EXAMINER <u></u> DATE SIGNED <u>Nov 13, 1960</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
22d. LOCATION (City, town, or country) <u>Suitland, Md.</u>		23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>			
24a. REC'D BY REGISTRAR <u>NOV 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

18910 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE

TIME

PLACE

BY

NAME

DEGREE

NO.

STATE

CITY

COUNTY

ZIP

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CERTIFICATE OF DEATH

12904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights				c. LENGTH OF STAY IN 1b 50yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5020 56 Avenue				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights			
f. STREET ADDRESS 5020 56 Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Glenn Middle Audleigh Last Hynson				4. DATE OF DEATH Month November Day 27 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 8, 1900	
9. AGE (In years lost birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Richmond County, Va.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Addison Glenn Hynson				14. MOTHER'S MAIDEN NAME Laura Belle Lampkin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-10-1224		17. INFORMANT Jane Thomas	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of Lung DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 11 o. m. 27 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1958 to Nov 27 1960 , that I last saw the deceased alive on 11/27/60 and that death occurred at 1:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Barry Rosenberg M.D.				ADDRESS (Street, city or town, state) 5102 Annapolis Rd			
PHYSICIAN'S NAME (Type) Barry Rosenberg, M.D.				DATE SIGNED 11/28/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE NOV 29 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12076

1. NAME OF DECEASED George		2. SEX Male		3. AGE 30 yrs.	
4. PLACE OF BIRTH Maryland		5. PLACE OF DEATH Baltimore		6. DATE OF DEATH February 2, 1924	
7. STREET ADDRESS 2020 E. Avenue		8. CITY Baltimore		9. COUNTY Baltimore	
10. STATE Maryland		11. ZIP CODE 21202		12. MARRIAGE STATUS Married	
13. NAME OF SPOUSE Mary		14. NAME OF FATHER John		15. NAME OF MOTHER Mary	
16. OCCUPATION None		17. CAUSE OF DEATH Heart Disease		18. MEDICAL HISTORY None	
19. SIGNATURE OF PHYSICIAN J. H. Jones		20. SIGNATURE OF CORONER J. H. Jones		21. SIGNATURE OF WITNESS J. H. Jones	
22. NAME OF FUNERAL HOME None		23. NAME OF BURIAL PLACE None		24. NAME OF CEMETERY None	
25. NAME OF NEXT OF KIN None		26. NAME OF ATTORNEY None		27. NAME OF CLERGYMAN None	
28. NAME OF MINISTER None		29. NAME OF CHURCH None		30. NAME OF SYNAGOGUE None	
31. NAME OF MOSQUE None		32. NAME OF TEMPLE None		33. NAME OF OTHER PLACE None	
34. NAME OF OTHER PLACE None		35. NAME OF OTHER PLACE None		36. NAME OF OTHER PLACE None	
37. NAME OF OTHER PLACE None		38. NAME OF OTHER PLACE None		39. NAME OF OTHER PLACE None	
40. NAME OF OTHER PLACE None		41. NAME OF OTHER PLACE None		42. NAME OF OTHER PLACE None	
43. NAME OF OTHER PLACE None		44. NAME OF OTHER PLACE None		45. NAME OF OTHER PLACE None	
46. NAME OF OTHER PLACE None		47. NAME OF OTHER PLACE None		48. NAME OF OTHER PLACE None	
49. NAME OF OTHER PLACE None		50. NAME OF OTHER PLACE None		51. NAME OF OTHER PLACE None	
52. NAME OF OTHER PLACE None		53. NAME OF OTHER PLACE None		54. NAME OF OTHER PLACE None	
55. NAME OF OTHER PLACE None		56. NAME OF OTHER PLACE None		57. NAME OF OTHER PLACE None	
58. NAME OF OTHER PLACE None		59. NAME OF OTHER PLACE None		60. NAME OF OTHER PLACE None	
61. NAME OF OTHER PLACE None		62. NAME OF OTHER PLACE None		63. NAME OF OTHER PLACE None	
64. NAME OF OTHER PLACE None		65. NAME OF OTHER PLACE None		66. NAME OF OTHER PLACE None	
67. NAME OF OTHER PLACE None		68. NAME OF OTHER PLACE None		69. NAME OF OTHER PLACE None	
70. NAME OF OTHER PLACE None		71. NAME OF OTHER PLACE None		72. NAME OF OTHER PLACE None	
73. NAME OF OTHER PLACE None		74. NAME OF OTHER PLACE None		75. NAME OF OTHER PLACE None	
76. NAME OF OTHER PLACE None		77. NAME OF OTHER PLACE None		78. NAME OF OTHER PLACE None	
79. NAME OF OTHER PLACE None		80. NAME OF OTHER PLACE None		81. NAME OF OTHER PLACE None	
82. NAME OF OTHER PLACE None		83. NAME OF OTHER PLACE None		84. NAME OF OTHER PLACE None	
85. NAME OF OTHER PLACE None		86. NAME OF OTHER PLACE None		87. NAME OF OTHER PLACE None	
88. NAME OF OTHER PLACE None		89. NAME OF OTHER PLACE None		90. NAME OF OTHER PLACE None	
91. NAME OF OTHER PLACE None		92. NAME OF OTHER PLACE None		93. NAME OF OTHER PLACE None	
94. NAME OF OTHER PLACE None		95. NAME OF OTHER PLACE None		96. NAME OF OTHER PLACE None	
97. NAME OF OTHER PLACE None		98. NAME OF OTHER PLACE None		99. NAME OF OTHER PLACE None	
100. NAME OF OTHER PLACE None		101. NAME OF OTHER PLACE None		102. NAME OF OTHER PLACE None	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12906

12917

Item 7 Film G276 12-5-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN IL <u>2 mo 15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RUFUS SAMUEL JACKSON</u>		4. DATE OF DEATH <u>Nov 27 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8 1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Susan Whitening</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>5025 90181 ST NE</u>	
17. INFORMANT <u>Henry Jackson</u>		Address <u>5025 90181 ST NE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Confluent Broncho Pneumonia</u> <u>and</u> <u>936.9</u> DUE TO <u>Massive Cerebral Necrosis RT</u> <u>2 mo 15 days</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sub-Dural hematoma RT</u> <u>2 mo 15 days</u> (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>unknown</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Unknown</u> p. m. <u>Unknown</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> <u>Unknown</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Unknown</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov 27-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/1/60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Rd. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Washington</u>		ADDRESS <u>4925 Denne Ave NE</u>	
24a. REC'D BY REGISTRAR <u>DEC 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Clifton S. Harris</u>	

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12907

Item 8 Film G274 11-9-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES First ARTHUR Middle JOHNSON Last		4. DATE OF DEATH NOV. 5 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1889 1898
9. AGE (In years from birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Balto. Gas Co.	11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Johnson		14. MOTHER'S MAIDEN NAME Nancy Walls	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Lucille Johnson		Address Same as # 2 (Wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Surgical Shock 812x DUE TO Cerebral lacerations & fractures Conditions, if any, which gave rise to immediate cause (b) Fractured skull moments (c) cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject struck by Auto on Highway	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 11/5 1960 p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) College Park (County) Pr. Geo. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O. Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/ 60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice		ADDRESS 661 W. Barre Street	
24a. REC'D BY REGISTRAR DATE NOV 9 '60		24b. REGISTRAR'S SIGNATURE Charles E. Hanes	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
M
12918
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12908

1. PLACE OF DEATH e. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beltsville			
c. LENGTH OF STAY in 1b 12 hrs 50 min				d. STREET ADDRESS 11907 Ellington Drive			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clarence Johnson				4. DATE OF DEATH November 19, 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2, 1958	
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Elmore Johnson				14. MOTHER'S MAIDEN NAME Margaret Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Margaret Helena Thomas, same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 872.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Salicylate poisoning (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Ingested salicylates			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Nov. 19, 1960				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Home			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Beltsville P. G. Md				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED November 19, 1960			
EXAMINER'S NAME (Type) James I. Boyd				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-23-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington Virginia	
23. FUNERAL DIRECTOR Henry S. Washington				4925 Boone Ave NE.		24a. RECEIVED BY REGISTRAR NOV 25 1960	
						24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

2
16
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12919

12969

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12919

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 31			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle G. Last Kohler				4. DATE OF DEATH Month Nov. Day 24 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-26-94	
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Stationery Engineer		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Bertha Miller				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --			
16. SOCIAL SECURITY NO. --				17. INFORMANT Ella Hedges Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Epidemic Paro. Both Left Lung DUE TO (c) lyng cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-25 19 60 to 11-24 19 60 , that (I) (we) last saw the deceased alive on 11-24 19 60 , and that death occurred at 9:05 A.M. the causes and on the date stated above.				22a. SIGNATURE A Deitz, M.D. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE 11-26-60			
22c. PHYSICIAN'S NAME (Type) A Deitz, M.D.				22d. ADDRESS Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov 26, 1960			
23c. NAME OF CEMETERY OR CREMATORY Washington National				23d. LOCATION (City, town, or county) (State) Suitland Md.			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR NOV 29 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

UNITED STATES OF AMERICA

1901

THE STATE OF NEW YORK
IN SENATE
January 1, 1901
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899
ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.
1901.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12911											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale						c. LENGTH OF STAY IN 1b 61					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital						d. STREET ADDRESS West, Hyattsville					
3. NAME OF DECEASED (Type or print) CARRIE VIRGINIA LAMPHIER						4. DATE OF DEATH November 11, 1960.					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 11/17/1899		9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR 60 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State for foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew S. Mckeown						14. MOTHER'S MAIDEN NAME Olive Nichols					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. W.W. I					
17. INFORMANT Mr. L. I. Lamphier, Sr.						Address Same as #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage											
DUE TO (b) Cerebral Arteriosclerosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED November 11, 1960.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 11/15/60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or country) (State) Colmar Manor, Prince George's, Md.	
23. FUNERAL DIRECTOR Nalley's Funeral Home						ADDRESS 4th Rainier		24a. REC'D BY REGISTRAR NOV 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Done

THE
PLATE
NO.

1

Beland Memorial Hospital

CARLE VIRGINIA

Female White

Housewife

Married S. Unknown

Age 40

Intercranial Hemorrhage

Cerebral Arteriosclerosis

JAMES I. FORD, M.D.

November 11, 1930

12977

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PR. GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b 19 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SOUTHERN MARYLAND HOSP. CENTER		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILHELMINA LANGE		4. DATE OF DEATH Month Day Year NOV. 27 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	12. BIRTHPLACE (State or foreign country) CANADA
13. FATHER'S NAME WILLIAM SCHALIN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G.I. TRACT HEMORRHAGE, UREMIA DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPTICEMIA WITH PYELONEPHRITIS DUE TO 23 DAYS (c) DIABETES MELLITIS DUE TO 23 DAYS		INTERVAL BETWEEN ONSET AND DEATH 4 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour NONE		20d. INJURY OCCURRED NONE	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE		20f. (City or town) (County) (State) NONE	
21. I certify that I attended the deceased from NOV. 8, 1960 , to Present , that I last saw the deceased alive on NOV. 26, 1960 , and that death occurred at 9:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Shaver		DATE SIGNED 11/27/60	
PHYSICIAN'S NAME (Type) ARTHUR SHAVER TR MD		ADDRESS (Street, city or town, state) BRANCH AVE. CLINTON, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-60	
22c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens		22d. LOCATION (City, town, or county) (State) Waldorf (Ches) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Sumner Bros		24a. REC'D BY REGISTRAR DATE NOV 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Shaver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1907

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH

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12953

CERTIFICATE OF DEATH

Reg. Dist. No.

12912

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 11 Days		d. STREET ADDRESS 4212 Park Heights Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Also Lena or Lina) (Type or print) Antoinette (NMI) LaRosa		4. DATE OF DEATH Nov. 27, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1887
9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Salvatore Cucina		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Rosa Damico, 4300 Woodridge Rd. Balto. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage & Cardiac Failure DUE TO (c) Cerebral Hemorrhage & Cardiac Failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-16, 1960, to 11-27, 1960, that I last saw the deceased alive on 11-26, 1960, and that death occurred at 12:05 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Adolfo Pirandrea - M.D. 305 Prince George St. Laurel, Md. 11-27-60 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/60	
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
G. Vernon Lemmon, 4611 Park Heights, Balto. Md.		DATE NOV 29 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10. REMARKS:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12920
12913
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash., 22 D.C. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Wash., 22, D.C.	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 1 6997 Allentown Rd	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George (NMN) Lincoln		4. DATE OF DEATH November 24 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/20/1891	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer Retired US Gov't		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Lincoln		14. MOTHER'S MAIDEN NAME Mary Elizabeth Phelps	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George F. Lincoln, 5726 East Pines Dr. Riverdale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute pul. edema (b) Arterio sclerotic Ht. Hds. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 22 1960 to Nov. 24 1960, that (I) (we) last saw the deceased alive on 11/24/1960, and that death occurred at 10:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Albert Roth		22b. DATE SIGNED 11/25/1960	
22c. PHYSICIAN'S NAME (Type) Albert Roth		22d. ADDRESS 5510 Madison Street, Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/29/1960	
23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO. Riverdale, Md		25a. REC'D BY REGISTRAR NOV 29 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur J. Thomas	

CHANDLER, R. D. 1963. *Journal of the Royal Society of Medicine* 56: 101-102.

CHILDREN'S RIGHTS INTERNATIONAL

Item 18 Film 274 11-16-60 ams		MAYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND		12978		12914	
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE			
c. LENGTH OF STAY IN lb 15 DAYS				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, ANDREWS AFB, WASH, DC			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE CALIFORNIA b. COUNTY FRESNO			
3. NAME OF DECEASED (Type or print) First Middle Last EDWIN WILLIAM LIPPINCOTT				4. DATE OF DEATH Month Day Year NOVEMBER 10 1960			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 20 June 1920	
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) 1 Oregon		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE				10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE			
13. FATHER'S NAME Fred S. Lippincott, Sr.				14. MOTHER'S MAIDEN NAME Elizabeth (maiden name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 1941-46 51-60 723-120-4850			
17. INFORMANT HOSPITAL AND PERSONNEL RECORDS				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350X DUE TO ARRHYTHMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) WOLFF PARKINSON WHITE SYNDROME DUE TO (c) unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 27 Oct 1960 to 10 Nov 1960 and that death occurred at 11:50 AM from the causes and on the date stated above.							
22a. SIGNATURE Edwin E. Westura				22b. DATE SIGNED 10 Nov 60			
22c. PHYSICIAN'S NAME (Type) EDWIN E WESTURA CAPT USAF MC				22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF Nov. 16, 1960			
23c. NAME OF CEMETERY OR CREMATORY WASHINGTON				23d. LOCATION (City, town, or county) (State) FRESNO CALIFORNIA			
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME				25a. REC'D BY REGISTRAR DATE NOV 14 '60			
ADDRESS 816 H ST. N.E., DC 2				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

15078

1. NAME OF DECEASED: _____

2. SEX: _____

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. MARITAL STATUS: _____

8. CAUSE OF DEATH: _____

9. PLACE OF DEATH: _____

10. DATE OF DEATH: _____

11. SIGNATURE OF PHYSICIAN: _____

12. SIGNATURE OF REGISTRAR: _____

13. SIGNATURE OF WITNESS: _____

14. SIGNATURE OF DECEASED: _____

15. SIGNATURE OF NEXT OF KIN: _____

16. SIGNATURE OF BURIAL OFFICIAL: _____

17. SIGNATURE OF FUNERAL HOME: _____

18. SIGNATURE OF CHURCH: _____

19. SIGNATURE OF CEMETERY: _____

20. SIGNATURE OF OTHER: _____

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12921

12915

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs 1519-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 8621 Piney Branch Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lena		First		Middle Miller		Last Little	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 October 1888	
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE MILLER		14. MOTHER'S MAIDEN NAME PHEBE STRYKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. yes		17. INFORMANT Mr. Frank H. Little, 8621 Piney Branch Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1544X Maemia DUE TO (b) Abdominal - Perineal Abscess DUE TO (c) Adeno - Carcinoma of Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/12 19 60 , to 11/5 19 60 , that (I) (we) lost saw the deceased alive on 11/5 19 60 , and that death occurred at 3:15 PM from the causes and on the date stated above.							
22a. SIGNATURE Saul Schwartzbach M.D.				22b. DATE SIGNED 11/5/60		22c. PHYSICIAN'S NAME (Type) Dr. Saul Schwartzbach M.D.	
22d. ADDRESS 1726 Eye St. N.W. Washington, D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/7/60		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond D. Ziska				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR NOV 9 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

1921

Name of Deceased		Age		Sex	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Burial Place	
Signature of Physician		Signature of Registrar		Signature of Witnesses	
Date of Certificate		Place of Issuance		Official Seal	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12916

12922

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hasel Martin Lloyd				4. DATE OF DEATH Month Day Year Nov. 16 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1907	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Engineer		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Lloyd				14. MOTHER'S MAIDEN NAME Lydia Norton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Address Florence E Lloyd Roger Heights, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myo cardiac infarct DUE TO (b) Cardiac tamponade DUE TO (c) Atherosclerotic Hds - INTERVAL BETWEEN ONSET AND DEATH 6 day 1 hr several yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov 1st 1956 to Nov. 16 1960 , that (I) (we) last saw the deceased alive on Nov. 16th 1960 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Til Bergman, M.D.							
22b. DATE SIGNED 11 16-60							
22c. PHYSICIAN'S NAME (Type) Dr. Til Bergman, M.D.							
22d. ADDRESS 3 D Crescent Road, Green Belt, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
23b. DATE THEREOF Nov 19, 1960							
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery							
23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville, Maryland.							
25a. REC'D BY REGISTRAR DATE NOV 21 '60							
25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12917

12923

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 hrs. 5 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 2202 Cheverly Avenue							
3. NAME OF DECEASED (Type or print) First John Middle T. Last Maloney				4. DATE OF DEATH Month Nov Day 3 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 22, 1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Edward L. Maloney				14. MOTHER'S MAIDEN NAME Margaret Delaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXX Yes				16. SOCIAL SECURITY NO. WW 1		17. INFORMANT Mrs. Mary L. Maloney (Wife) Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Inten-cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Syns				INTERVAL BETWEEN ONSET AND DEATH 10 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington D. C.				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1960 to Nov 3 , 1960, that (I) (we) last saw the deceased alive on Nov 3 , 1960, and that death occurred at 3:50 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Norman Donald Comrau				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Norman Donald Comrau				22d. ADDRESS 3503 Pennyslt Mt Rainier Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/7/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town, or county) (State) Washington D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 9 '60	
				25b. REGISTRAR'S SIGNATURE Arthur E. Kenna			

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SSOS Charvát & Váňa

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Journal

January 2002, SS 2002

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1413. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/159

Novo

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12959 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12918											
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) b. STATE Maryland c. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital						d. STREET ADDRESS Route 1, Box 63					
3. NAME OF DECEASED (Type or print) KENNETH WAYNE MANN						4. DATE OF DEATH November 24, 19 60.					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1960		9. AGE (In years last birthday) 3		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY Infant				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gilmer Mann						14. MOTHER'S MAIDEN NAME Gladys Louise Mabe					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Gladys L. Mann				Address Route #1, Box 63 Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Hemorrhagic 4933X DUE TO Salivator Bilateral Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 2 days. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dayton Watkins						DATE SIGNED November 24, 1960.					
EXAMINER'S NAME (Type) DAYTON O. WATKINS, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Nov. 27, 1960		22c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		22d. LOCATION (City, town, or country) (State) Abingdon, Virginia.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.						24a. REC'D BY REGISTRAR NOV 28 60		24b. REGISTRAR'S SIGNATURE Arthur S. House			

MEDICAL CERTIFICATION

W. CHAMBERS & CO. LONDON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12924

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12919

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Stella First M Middle McAvoy Last				4. DATE OF DEATH Month Nov Day 27 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Apr. 1889	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) NEAR BOONSBORO WASH. Co. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HENRY SMITH				14. MOTHER'S MAIDEN NAME ANNA CLARA FURRY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. 215-20-9935A			
17. INFORMANT 5823 DEWEY ST. CHEVERLY MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade 420.1 DUE TO Myocardial Infarction with rupture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis of Right Coronary Artery DUE TO Coronary Arteriosclerotic Heart Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes 4 days 4 days years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 23 19 60 to Nov. 26 19 60 , that (I) (we) last saw the deceased alive on 26 Nov 19 60 , and that death occurred at 5, 40 AM from the causes and on the date stated above.							
22a. SIGNATURE Francis D. DeCoste M.D.				22b. DATE SIGNED 11/27/60			
22c. PHYSICIAN'S NAME (Type) Dr. Frances DeCoste., MD				22d. ADDRESS 9608 Underwood St. Seabrook., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BORIAL		23b. DATE THEREOF NOV. 29. 1960		23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		23d. LOCATION (City, town, or county) (State) BOONSBORO WASH. Co. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Barth Funeral Home				25a. REC'D BY REGISTRAR DEC 1 '60			
25b. REGISTRAR'S SIGNATURE Charles S. Kline							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G276 12-7-60 et

12979

CERTIFICATE OF DEATH

Reg. Dist. No.

12920

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Bedford Hgts.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6405 - Shreff. Pk. 30</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Bedford Hgts. W.P. 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M</u> Last <u>Bridg</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-1894</u> 66 yrs.
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>unk</u>	
14. MOTHER'S MAIDEN NAME <u>unk</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u> </u>		INFORMANT <u>Mrs. Mary Robinson</u> Address <u>4809 Shreff.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-24</u> , 19 <u>55</u> to <u>Nov. 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov. 25</u> , 19 <u>60</u> , and that death occurred at <u>3:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. C. Beldor</u>		ADDRESS (Street, city or town, state) <u>4423 - Hunt - Pl. NE</u>	
PHYSICIAN'S NAME (Type) <u>H. C. Beldor MD Wash. D.C.</u>		DATE SIGNED <u>Nov 28 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-29-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle R. Gellum</u>		24a. REGISTRY REGISTRAR <u>4339 Hunt Pl., N.E. Wash. D.C.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fenne</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15079

DEPARTMENT OF HEALTH
STATE OF NEW YORK
BUREAU OF VITAL STATISTICS
ALBANY, N. Y.

12921

12965

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Seat Pleasant</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6925 Adel Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>BERTHA</u> Last <u>MC GINNIS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13. BIRTHPLACE (State or foreign country) <u>New Orleans, Louisiana</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>WILLIAM WALDSAUR</u>		16. MOTHER'S MAIDEN NAME <u>VIRGINIA ROUSSE</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>—</u>	
19. INFORMANT <u>Mrs. E. Hartshorn</u>		Address <u>6925 Adel St., Seat Pleasant, Md.</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Coroner - Vascular</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal disease</u> DUE TO (c) <u>15 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 15, 1940</u> to <u>Nov. 6, 1960</u> that I last saw the deceased alive on <u>November 6, 1960</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		DATE SIGNED <u>11/6/60</u>	
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		<u>Capitol Heights Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-9-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudin's Sons, Inc.</u>		ADDRESS <u>1756 Pa. Ave. NW, Wash. D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	

VS A15 (4)
ISM 9/SB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. LENGTH OF STAY IN 1b <i>12 days</i>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>65 Riverdale</i>		d. STREET ADDRESS <i>5004 Queensbury Rd</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Keloland Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Hector</i> Middle <i>C</i> Last <i>McKnew</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>29</i> Year <i>1960</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-7-79</i>	
9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>1</i> Hours <i>15</i> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Benjamin P. McKnew</i>		14. MOTHER'S MAIDEN NAME <i>Deana Aitchison</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Hospital Record</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Coronary Thrombosis</i> DUE TO (c) <i>Arterio-sclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension & Cerebral Thrombosis.</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>11-17</i> 19 <i>60</i> to <i>11-28</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>11-28</i> 19 <i>60</i> , and that death occurred at <i>10:15</i> M, from the causes and on the date stated above.				
22a. SIGNATURE <i>D.R. Purdie</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>D.R. PURDIE</i>		22d. ADDRESS		
22b. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/2/60</i>		
23c. NAME OF CEMETERY OR CREMATORY <i>Ang Hill Cemetery Laurel Md</i>		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>D. P. Pittman</i>		ADDRESS <i>Laurel, Md</i>		
25a. REC'D BY REGISTRAR <i>DEC 9 '60</i>		25b. REGISTRAR'S SIGNATURE <i>C. L. H. K...</i>		

1930

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

12925
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12922

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3004 Perry St. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John E Merriken		4. DATE OF DEATH Month Day Year November 9 1960	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-81
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee D.C. National Guard		12. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
13. FATHER'S NAME George Merriken		14. MOTHER'S MAIDEN NAME Marian V. Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-30-7574	
17. INFORMANT Wilhelmina T. Merriken (As above)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c) 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 25 1959 to Nov. 9 1960 , that (I) (we) last saw the deceased alive on Nov. 9 1960 , and that death occurred at 9:45 am from the causes and on the date stated above.			
22a. SIGNATURE Charles C. Hageage		22b. DATE SIGNED Nov. 9, 1960	
22c. PHYSICIAN'S NAME (Type) Dr. Chas. Hageage		22d. ADDRESS 3308 Perry Street, Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/1960	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) Colmar Manor, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.		25a. REC'D BY REGISTRAR DATE NOV 14 '60	
ADDRESS Mt. Rainier, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

12982

CERTIFICATE OF DEATH

DATE

12-10-1918

2 days

12-10-1918

12-10-1918

12-10-1918

John

12-10-1918

Baltimore, Maryland

Employee U.S. National Guard

12-10-1918

George Harrison

12-10-1918

12-10-1918



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12980

12923

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 7 months and 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 123 49th St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle O. Last Milburn				4. DATE OF DEATH Month 11 Day 29 Year 19 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/15	
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Milburn				14. MOTHER'S MAIDEN NAME Aline Gladden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown (lost)		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, primary site undetermined 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, far advanced, active (11 mos.)						INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/1/1960 to 11/29/60, that (I) (we) last saw the deceased alive on 11/29/60, and that death occurred at A.M., from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/29/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-8-60		23c. NAME OF CEMETERY OR CREMATORY St Marks Church Cem.		23d. LOCATION (City, town, or county) (State) Valley Lee Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Johnson & Johnson				ADDRESS 4804 Balow N.W.		25a. REC'D BY REGISTRAR DATE DEC 2 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

12852

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12926											
12924											
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 5th and Lincoln Avenue					
3. NAME OF DECEASED (Type or print) ELIZABETH CIVILLE MILES						4. DATE OF DEATH Month November Day 24 , Year 1960					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1876		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 30 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Ret.		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) St. Mary's Cty., Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Statesman						14. MOTHER'S MAIDEN NAME Henrietta Statesman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. None					
17. INFORMANT Mrs. Victoria Holmes						Address 726 59th Ave., Fairmont, Md. Hgts.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart disease (C Pulmonary edema) DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arterio Sclerosis Generalized (c) 1 year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUE TO 30 min DUE TO 1 year											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dayton O Watkins						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) DAYTON O. WATKINS, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED November 24, 1960					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Nov. 29, 1960		22c. NAME OF CEMETERY OR CREMATORY New Harmony Pk. Cemetery Prince Geo. Cty., Md.		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR HENRY WASHINGTON						ADDRESS 4927 Deane Ave N.W. Wash. D.C.			24a. REC'D BY REGISTRAR NOV 29 '60		
24b. REGISTRAR'S SIGNATURE Arthur S. Kross											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

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12927
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
12925

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 Hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph I Milstead		4. DATE OF DEATH Month Day Year Nov. 12 n 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-82
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME TRUMAN MILSTEAD		14. MOTHER'S MAIDEN NAME ANNIE MILSTEAD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. YES	
17. INFORMANT MRS EDNA B. MILSTEAD		Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Fibrosis and Calcification (c) Chronic Adhesive Pericarditis (d) Coronary Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 24 hours 20 years 10 years 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus (cause undetermined)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 12 1960, to Nov. 12 1960, that (I) (we) last saw the deceased alive on Nov. 12 1960 and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Chas. David Connors, M.D.		22b. DATE 11-14-60	
22c. PHYSICIAN'S NAME (Type) Dr. Chas. David Connors, M.D.		22d. ADDRESS 4813 Landover Road, Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-16-1960	
23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON MEMORIAL		23d. LOCATION (City, town, or county) (State) HYATTSVILLE, MD	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co		25a. REC'D BY REGISTRAR DATE NOV 18 '60	
ADDRESS Baltimore, Md		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1957

1. Name of deceased: TRUMAN, MARY ANN

2. Sex: F

3. Race: W

4. Date of birth: 11-11-1900

5. Place of birth: St. Louis, Mo.

6. Date of death: 11-11-1957

7. Place of death: St. Louis, Mo.

8. Cause of death: Heart disease

9. Duration of illness: 10 days

10. Signature of physician: [Signature]

11. Signature of registrar: [Signature]

12. Date of registration: 11-11-1957

13. Place of registration: St. Louis, Mo.

14. Name of registrar: [Name]

15. Signature of informant: [Signature]

16. Name of informant: [Name]

17. Address of informant: [Address]

18. Date of interview: 11-11-1957

19. Name of interviewer: [Name]

20. Signature of interviewer: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12928

12926

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS 1101 28 th Place			
3. NAME OF DECEASED (Type or print) First John Middle NAKSHIAN Last Nakshian				4. DATE OF DEATH Month Nov. Day 21 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21 19 60	
9. AGE (In years last birthday) 80 yrs.		10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machineist				10b. KIND OF BUSINESS OR INDUSTRY Belt for Machine America			
11. BIRTHPLACE (State or foreign country) Armenia				12. CITIZEN OF WHAT COUNTRY? Armenia			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 294-03-3015			
17. INFORMANT Miss Alice Nakshian				Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Arterio sclerotic Ht dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 19 19 60 , to Nov. 21 19 60 , that (I) (we) last saw the deceased alive on Nov. 21 19 60 , and that death occurred at 1:45 PM the causes and on the date stated above.							
22a. SIGNATURE Dr. Chas. David Connors, M.D.				22b. DATE SIGNED Nov. 21 1960			
22c. PHYSICIAN'S NAME (Type) Dr. Chas. David Connors, M.D.				22d. ADDRESS 5813 Landover Road, Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-23-1960		23c. NAME OF CEMETERY OR CREMATORY St. Agnes Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Chas. E. Chambers & Co.				25a. REC'D BY REGISTRAR Nov 28 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

121128

THIS CERTIFICATE OF DEATH is to be filled out by the physician or other person who has attended the deceased, or by the coroner, or by the registrar of deaths, or by the person who has taken charge of the funeral, or by the person who has taken charge of the burial, or by the person who has taken charge of the interment, or by the person who has taken charge of the cremation, or by the person who has taken charge of the other disposal of the body of the deceased.

Full name of deceased: [illegible]
Age: [illegible]
Sex: [illegible]
Date of birth: [illegible]
Place of birth: [illegible]
Date of death: [illegible]
Place of death: [illegible]
Cause of death: [illegible]
Signature of physician: [illegible]
Signature of registrar: [illegible]
Signature of coroner: [illegible]
Signature of funeral director: [illegible]
Signature of burial director: [illegible]
Signature of cremation director: [illegible]
Signature of other disposal director: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12929

12927

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Georges General				c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. 47X-	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 1413 Buchanan St. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert First Middle Nemer Last				4. DATE OF DEATH Month Nov Day 19 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 Mar. 1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Syria	
12. CITIZEN OF WHAT COUNTRY? Syria ✓							
13. FATHER'S NAME Farrah Nemer				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Robert W. McCormick- 801 Somerset Place Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Acute Coronary Infarction DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov. 14, 1960 to 19 Nov. 1960 that (I) (we) last saw the deceased alive on 19 Nov. 1960, and that death occurred on 19 Nov. 1960 from the causes and on the date stated above.							
22a. SIGNATURE Charles C. Hageage M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles C. Hageage M.D.				22d. ADDRESS 3717 38th Avenue, Cottage City, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/60		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co., ADDRESS 2901-15th St. N.W.				25a. REC'D BY REGISTRAR DATE NOV 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

12323

1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12981

CERTIFICATE OF DEATH

Reg. Dist. No. 12928

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Washington D.C. 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hgts.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.			
c. LENGTH OF STAY IN 1b 2 days				d. STREET ADDRESS 1121 New Hampshire Ave. N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5909 24th Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Della		First Middle Last O'Neill,		4. DATE OF DEATH 11-24-1960		Month Day Year.	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1881 79	
9. AGE (In years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gov't		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eugene		14. MOTHER'S MAIDEN NAME Della Donohue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT RUTH YOUNG - 5909 24th Ave. Hill Crst		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive ASHD (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/23, 1960, to 11/24, 1960, that I last saw the deceased alive on 11/24, 1960, and that death occurred at M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David Lenarduzzi				ADDRESS (Street, city or town, state) DATE SIGNED 2901 Fairbairn St SE 11/26/60			
PHYSICIAN'S NAME (Type) David Lenarduzzi							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-28-60		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		22d. LOCATION (City, town, or county) (State) WASHT. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Haulon				ADDRESS WASH D.C.		24a. REC'D BY REGISTRAR DATE NOV 29 60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12081

DECEASED NAME JAMES H. HARRIS		SEX Male		AGE 68	
DATE OF BIRTH 1891		PLACE OF BIRTH Baltimore, Md.		RACE White	
STREET ADDRESS 1234 N. E. St.		CITY Baltimore		STATE Md.	
OCCUPATION Clerk		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH 1958		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF JURY (None)	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12982

12929

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill				c. LENGTH OF STAY IN 1b 17 Oxon Hill			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1398 Owens Rd S.E.				e. STREET ADDRESS 1398 Owens Rd., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ANNIE E OWENS				4. DATE OF DEATH Month Day Year Nov. 26 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1864	
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Wm Richard Moore				14. MOTHER'S MAIDEN NAME Margaret Farr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Beatrice O. Eno 2100-A 38th St., SE Washington DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident DUE TO (c) arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month 20 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1955, to Nov 26 1960, that (I) was last saw the deceased alive on Nov 26 1960, and that death occurred at 7 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert A. Dornbach M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov. 26 1960	
22c. PHYSICIAN'S NAME (Type) Robert A. Dornbach				22d. ADDRESS 4221--South Capitol St., Wash. DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-60		23c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		23d. LOCATION (City, town, or county) (State) Oxon Hill Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Demmona Bus 1661--Good Hope Rd SE Wash. 20 DC				25a. REC'D BY REGISTRAR NOV 29 '60		25b. REGISTRAR'S SIGNATURE Clinton S. Evans	

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INSTITUTE OF DESIGN

15083



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12930

12930

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 1 8141 Greenleaf Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stella Middle Parrish Last Parrish				4. DATE OF DEATH Month Nov Day 27 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 Nov 1891	
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months 08 Days 09 Hours 00 Min. 00		IF UNDER 24 HRS. Months 00 Days 00 Hours 00 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cresson, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David Sheehan				14. MOTHER'S MAIDEN NAME Lucy E. Lippton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT John N. Parrish,				8141 Greenleaf Rd., Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS (Generalized) 175.0 DUE TO Ovarian Carcinoma Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11-16-1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-16-1960 to 11-27-1960 , that (I) (we) last saw the deceased alive on 11-26-1960 , and that death occurred on 11-27-1960 from the causes and on the date stated above.							
22a. SIGNATURE Dr. Albert Roth M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/28/60	
22c. PHYSICIAN'S NAME (Type) Dr. Albert Roth M.D.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 20, 1960		23c. NAME OF CEMETERY OR CREMATORY St. Aloysius Cemetery		23d. LOCATION (City, town, or county) (State) Cresson Pa	
24. FUNERAL DIRECTOR'S SIGNATURE Robert R. Donaldson				ADDRESS Garret Md		25a. REC'D BY REGISTRAR DATE NOV 29 '60	
						25b. REGISTRAR'S SIGNATURE Arthur L. House	

100-100000

CERTIFICATE OF DEATH

15000

Prison Number

Prison Number

Prison Number

Prison Number

Prison Number

Prison Number

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Prison Number

Reg. Dist. No.

VS AIS (4)
15M 9/SS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12961

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12932

1. PLACE OF DEATH a. COUNTY <u>Prince George, Riverdale</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg, Md</u> 40			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial</u>				d. STREET ADDRESS <u>5101 Tilden Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Rosa</u> Last <u>Perell</u>				4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5- -1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Argentina, So America</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Joseph ?</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>James J. Perell and Same as above.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>D. Diabetes</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 22, 1960</u> to <u>Nov 23, 1960</u> that (I) (we) lost the deceased alive on <u>Nov 23, 1960</u> and that death occurred at <u>2 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L W Malin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>11-23-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>				22d. ADDRESS <u>Riverdale, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 26, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chong ben Co</u> ADDRESS <u>5801 Cleveland Ave</u>				25a. REC'D BY REGISTRAR <u>NOV 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12983

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12983

1. PLACE OF DEATH a. COUNTY <u>Prince George's Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Danville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Danville,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mattie</u> First <u>M.</u> Middle <u>Pinkney</u> Last				4. DATE OF DEATH <u>November 7</u> 19 <u>60</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25-1921</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Burrough</u>				14. MOTHER'S MAIDEN NAME <u>Cora Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Herbert Pinkney</u> Address <u>Danville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>171X</u> DUE TO <u>urine</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Carcinoma (diverted)</u> DUE TO (c) <u>Cancer of cervix</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-5</u> 19 <u>57</u> to <u>11-7</u> 19 <u>60</u> ; that (I) (we) last saw the deceased alive on <u>11-7</u> 19 <u>60</u> and that death occurred at <u>4:08</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Dobson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>				22d. ADDRESS <u>Burlington, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 10/1960</u>		23c. NAME OF GEMETERY OR CREMATORY <u>Gibbons Church</u>		23d. LOCATION (City, town, or county) (State) <u>Brandywine, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Nelson</u> ADDRESS <u>Aquasco, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV/9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

15083

CERTIFICATE OF DEATH

1

NAME OF DECEASED *John J. Smith*

AGE *45*

SEX *Male*

RACE *White*

DATE OF DEATH *Jan 15 1915*

PLACE OF DEATH *Home*

Cause of Death *Heart Disease*

Signature of Registrar *[Signature]*

Signature of Physician *[Signature]*

Signature of Coroner *[Signature]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12931

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b D O A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro Md	
f. STREET ADDRESS R F D Box 1460		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Renzie Last Proctor		4. DATE OF DEATH Month November Day 8 Year 19 60-	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1910
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Proctor		14. MOTHER'S MAIDEN NAME Rosetta Proctor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Elizabeth Dorothy Proctor		Address Upper Marlboro Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Congestive Heart failure DUE TO (c) Hypertensive Cardiovascular disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O. Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dayton O. Watkins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Nov 8, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-11-60	
22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) Oxon Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhine Co.		ADDRESS 3015-12th St. N.E. D.C.	
24a. REC'D BY REGISTRAR DATE NOV 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thrash	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12984
CERTIFICATE OF DEATH

Reg. Dist. No.

12935

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi		c. LENGTH OF STAY IN 1b 5 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,100 Vireo St.		d. STREET ADDRESS 10, 100 Vireo St.	
3. NAME OF DECEASED (Type or print) First Lela Middle Estelle Last Proffer		4. DATE OF DEATH Month Nov. Day 12 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1896
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Proffer		14. MOTHER'S MAIDEN NAME Shabie E. Hampton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 119-32-6005	
17. INFORMANT Ila Proffer		Address 10,100 Vireo St., Adelphi, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.2 Inanition DUE TO (b) Carcinoma of Descending Colon DUE TO (c) 4 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 11 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1960, to Aug. 12, 1960, that I last saw the deceased alive on Aug. 10, 1960, and that death occurred at 4:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Claire A. Christman M.D.		ADDRESS (Street, city or town, state) 9703 Riggs Rd., Adelphi, Md.	
DATE SIGNED 11-12-60			
PHYSICIAN'S NAME (Type) Claire A. Christman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/14/60	
22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PIMPHREY, INC. Raymond E. Pimphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE NOV 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12985

CERTIFICATE OF DEATH

12936

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				c. LENGTH OF STAY IN 1b 4 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) USAF Hospital Andrews				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle TIETJEN Last QUINN				4. DATE OF DEATH Month November Day 15 Year 1960			
5. SEX Male	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1924		9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER, Retired		10b. KIND OF BUSINESS OR INDUSTRY USAir Force		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME MICHAEL R. QUINN				14. MOTHER'S MAIDEN NAME LUISE THEE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1944-1960		17. INFORMANT Address Wife 101 Cedar Lane, Potomac Hgts, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYELOGENOUS LEUKEMIA 204.13 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9 MO							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24 FEB 1960 to 15 NOV 1960 , that (I) (we) last saw the deceased alive on 15 NOV 1960 , and that death occurred at 8:20 AM , from the causes and on the date stated above.							
22a. SIGNATURE Andrew W. Butchko				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 15 NOV 60	
22c. PHYSICIAN'S NAME (Type) ANDREW W BUTCHKO, CAPT USAF MC				22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 18 NOV. 1960		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME 816 HSL, N.E., WASH 2 DC				25a. REC'D BY REGISTRAR NOV 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

12382

1



1



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12932

12937

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE (D.C.) Md. b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 31			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George				d. STREET ADDRESS 1516 62nd. Place S.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Anne Middle Mary Last Raum		4. DATE OF DEATH Month Nov. Day 24 Year 1960					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25th 1887	9. AGE (In years last birthday) 72 3/4 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Chicago Ill		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Smith				14. MOTHER'S MAIDEN NAME Annie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Daniel R. Raum Carmody Hills Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shuntate occel. 18 the left cor. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) art. to mya at 16 the left veins DUE TO (c) Arterio sclerotic Ht dis.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-21- 1960 to 11-24- 1960 that (I) (we) last saw the deceased alive on 11-23- 1960 , and that death occurred at 12:55 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Hans Wodak</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-24-1960	
22c. PHYSICIAN'S NAME (Type) Hans Wodak				22d. ADDRESS 9E Parkway Greenbelt, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-28-60		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W.W.Chambers Co. 517 11th St. S.E. Wash. D.C.				25a. REC'D BY REGISTRAR NOV 28 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>adm. 10-21-60</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>R</u> Last <u>REED</u>		4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-1875</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>	11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SYLVESTER REED</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE VANAMBER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>577-18-6763</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>Apoplexy (334)</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO <u>several yrs</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8-10 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis Dementia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-21-</u> , 19 <u>60</u> , to <u>11-22-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11-22-</u> , 19 <u>60</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Linda P. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM</u> DATE SIGNED <u>11-22-60</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREL MARKLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/25/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Jones Co.</u>		24a. REGISTERED BY <u>2905-14th St. N.W. Wash. D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>		DATE <u>NOV 28 1960</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

24 JUL 1962 02 40
A 2 11 41 00 AM

15:25

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Signature of physician: [illegible]
6. Signature of registrar: [illegible]
7. Date of registration: [illegible]
8. Place of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12933

12933

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 6 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Mt. Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4000 36th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Linda B Reed				4. DATE OF DEATH Month Day Year Nov 27 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 July 1907	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk - Peoples Drug Store				10b. KIND OF BUSINESS OR INDUSTRY Orange Virginia		11. BIRTHPLACE (State or foreign country) U.S.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Henry Wakley				14. MOTHER'S MAIDEN NAME Mollie Gallahue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 579-203448				16. SOCIAL SECURITY NO. Ms. Rhoda Lee Zell - Daughter			
17. INFORMANT above				Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli 420 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Myocardial Infarction and mural thrombus DUE TO (c) Thrombosis of left anterior descending coronary Coronary Arteriosclerotic heart disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov. 21 1960 , to Nov. 27 1960 , that (I) (we) last saw the deceased alive on Nov. 26 1960 , and that death occurred at 3:00AM from the causes and on the date stated above.							
22a. SIGNATURE Dr. Chas. D. Connor, M.D.				22b. DATE SIGNED 11-27-60			
22c. PHYSICIAN'S NAME (Type) Dr. Chas. D. Connor, M.D.				22d. ADDRESS 5813 Landover Rd. Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		11/29/60		Cedar Hill		Suitland Prince Georges Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Mt. Rainier, Md.				25a. REC'D BY REGISTRAR DEC 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1898

John H. Haskins
John H. Haskins
John H. Haskins

John H. Haskins
John H. Haskins
John H. Haskins

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/59

12986

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12940

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN 1b 2 HRS 40 MIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, WASHINGTON, D C				d. STREET ADDRESS 1332 U ST SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle LOUIS Last RIOUX JR				4. DATE OF DEATH Month NOVEMBER Day 29 Year 19 60			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 NOVEMBER 1960	
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 40		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN LOUIS RIOUX				14. MOTHER'S MAIDEN NAME FRANCES PATRICIA PEROW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FATHER		Address SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Pulmonary atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2						INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours 40 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 29 Nov 19 60 to 29 Nov 19 60 , that (I) was last saw the deceased alive on 29 Nov 19 60 , and that death occurred at 4:10 PM , from the causes and on the date stated above.							
22a. SIGNATURE Leo R. Kairys				22b. DATE 29 NOVEMBER 1960			
22c. PHYSICIAN'S NAME (Type) LEO R KAIRYS CAPT USAF (MC)				22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1 DEC. 1960		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Russell Forward Howe				25a. REC'D BY REGISTRAR DEC 1 '60		25b. REGISTRAR'S SIGNATURE Carlton S. Howe	

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STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
OFFICE OF THE STATE HEALTH OFFICER
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
SAN FRANCISCO, CALIFORNIA

1920

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[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12941

1. PLACE OF DEATH a. COUNTY Prince George's. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 8 Hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 20 Laurel Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JUDY LYNN ROBERTSON				4. DATE OF DEATH Month Day Year Nov. 20 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1951			
9. AGE (in years last birthday) 9 yrs.		IF UNDER 1 YEAR Months Days 9		IF UNDER 24 HRS. Hours Min. 9					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY At School				11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Norman L. Robertson				14. MOTHER'S MAIDEN NAME Ruthalee V. Ervin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Ruthalee V. Robertson	
				Address 20 Laurel Hill Rd., Greenbelt, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Intestinal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal purpura DUE TO (c) Penicillin Reaction								INTERVAL BETWEEN ONSET AND DEATH 296X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sclerotic Lesion of Brain								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd				EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				DATE SIGNED November 21, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 23, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.,				ADDRESS Riverdale, Md.				24a. REC'D BY REGISTRAR NOV 23 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

3 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12987 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12942

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN TB Deadman		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Annapolis Base Hospital				d. STREET ADDRESS 17618 Atwood St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard Gary Robinson		First Middle Last		4. DATE OF DEATH Nov 22 1960		Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-60		9. AGE (In years last birthday) yrs. 8	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Joseph Robinson				14. MOTHER'S MAIDEN NAME Alice Elizabeth Neegan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT John Joseph Robinson, same as #2 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, LOBULAR, BILATERAL 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James J. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-22-60	
EXAMINER'S NAME (Type) James J. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25, 1960		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or country) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR RINALDI FUNERAL HOME, INC.		ADDRESS 816 H St. N.E. DC 20002		24a. REC'D BY REGISTRAR NOV 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Haines	

MEDICAL CERTIFICATION

2

2

VS. A15ME
5M 2159

2050223XVS

DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
1907

1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

12963

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12943

1. PLACE OF DEATH o. COUNTY LELAND MEM. HOSPITAL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PA. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McKEESPORT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LELAND MEM. HOSPITAL		d. STREET ADDRESS 1304 FAWCETT AVE.,	
3. NAME OF DECEASED (Type or print) CORA		4. DATE OF DEATH Nov. 10.	
5. SEX FEMALE		6. COLOR OR RACE COL.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		8. DATE OF BIRTH 2/24/92	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PITTS., PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM J. DADE		14. MOTHER'S MAIDEN NAME MARY E. SANDERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 171-26-8726	
17. INFORMANT Mrs. HENRIETTA JOSEPH		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary heart attack DUE TO (b) arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bells Palsy		INTERVAL BETWEEN ONSET AND DEATH 1 hour 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 19, 1960 to Nov 1, 1960 , that (I) (we) last saw the deceased alive on Nov 1, 1960 , and that death occurred at 2 A.M. from the causes and on the date stated above.			
22a. SIGNATURE W.S. Hudson		22b. DATE SIGNED 11/2/60	
22c. PHYSICIAN'S NAME (Type) W.S. HUDSON		22d. ADDRESS 509 R.I. ave N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11.4.60	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) McKEESPORT, PA.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT G. MCGUIRE		25a. REC'D BY REGISTRAR NOV 4 '60	
ADDRESS 1820 9TH ST., N.W.		25b. REGISTRAR'S SIGNATURE Arthur S. Kama	
WASHINGTON 1, D.C.			

U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Handwritten signature

REGISTRATION

DATE

PLACE OF DEATH

DATE OF DEATH

U.S. DEPARTMENT OF HEALTH

SEX

AGE

RACE

EDUCATION

RELIGION

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

INTERVENING CAUSE

PERIOD OF ILLNESS

DATE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF REGISTRAR

NAME OF WITNESS

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>12934</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>12944</div> </div> </div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Prince George's</div> <div>MARYLAND</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>MARYLAND</div> <div>b. COUNTY</div> <div>PRINCE GEORGES</div> </div> </div>															
<div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Cheverly</div> </div>				<div> <div>c. LENGTH OF STAY IN 1b</div> </div>				<div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Washington, D. C.</div> </div>				<div> <div>d. STREET ADDRESS</div> <div>1630 Massachusetts Ave., S.E.</div> </div>			
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>D.O.A. Prince George's Hosp.</div> </div>															
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>Ivan Houston</div> </div>		<div> <div>4. DATE OF DEATH</div> <div>Nov. 18, 1960</div> </div>		<div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>		<div> <div>5. SEX</div> <div>Male</div> </div>		<div> <div>6. COLOR OR RACE</div> <div>White</div> </div>		<div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div>		<div> <div>8. DATE OF BIRTH</div> <div>July 17, 1937</div> </div>			
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Attendant</div> </div>		<div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Service Station</div> </div>		<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>Moffattes Creek, Va.</div> </div>		<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div>		<div> <div>13. FATHER'S NAME</div> <div>Richard C. Rowe</div> </div>		<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Ethel M. Hardison</div> </div>					
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>No</div> </div>		<div> <div>16. SOCIAL SECURITY NO.</div> <div>226-44-0811</div> </div>		<div> <div>17. INFORMANT</div> <div>Mr. Richard C. Rowe, S.E., Wash., D.C.</div> </div>		<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Asphyxia</div> </div>		<div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>		<div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> </div>					
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> </div>		<div> <div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>Found on seat of his car with motor running</div> </div>		<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m.</div> <div>11 - 19</div> </div>		<div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> </div>		<div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> </div>		<div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div> </div>					
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</div> <div>Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/></div> </div>															
<div> <div>ACTUAL SIGNATURE</div> <div>James I. Boyd</div> </div>		<div> <div>EXAMINER'S NAME (Type)</div> <div>James I. Boyd</div> </div>		<div> <div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> </div>		<div> <div>DATE SIGNED</div> <div>November 18, 1960.</div> </div>		<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div>		<div> <div>22b. DATE THEREOF</div> <div>11-22-1960</div> </div>					
<div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>Washington National</div> </div>		<div> <div>22d. LOCATION (City, town, or country)</div> <div>Suitland, Maryland</div> </div>		<div> <div>23. FUNERAL DIRECTOR</div> <div>W. W. CHAMBERS CO., Riverdale, Md.</div> </div>		<div> <div>24a. REC'D BY REGISTRAR</div> <div>NOV 23 60</div> </div>		<div> <div>24b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Thomas</div> </div>		<div> <div>25. ADDRESS (Street, city, town, or county)</div> </div>					

WASHINGTON, D. C.

WASHINGTON, D. C.

George's

Washington, D. C.

1650 Massachusetts Ave., N.E.

D.C.A. George's Road.

Nov. 18, 1960

Rowe

Ivan Houston

July 17, 1957

Male White

Service Station Hoffman Creek, Va. U.S.A.

Attention

Richard M. Harbison

Richard G. Rowe

1650 Mass. Ave.

Mr. Richard G. Rowe, B.E., Wash., D.C.

Unknown

None



November 18, 1960

James I. Boyd

W. W. CHAMBERS CO., Riverdale, Md.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12935

12945

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO. COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PR</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3401 37th AVE 44</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEO. GEN. HOSP.</u>				d. STREET ADDRESS <u>Colmar Manor Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alexander Carl</u> First Middle Last <u>RUPARD</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN, 17, 1902</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>8</u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg.</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Joseph M</u>				14. MOTHER'S MAIDEN NAME <u>Rachael TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1919-1920</u>				16. SOCIAL SECURITY NO. <u>579-10-3782</u>			
17. INFORMANT <u>James #2</u> Address <u>Rupard (Wife)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420-1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> and <u>Pulmonary Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of Liver chronic</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 9</u> 19 <u>60</u> to <u>Nov 25</u> 19 <u>60</u> ; that (I) (we) last saw the deceased alive on <u>Nov 20</u> 19 <u>60</u> , and that death occurred at <u>3:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. Rosson</u> M.D.				22b. ADDRESS <u>5701 85th Ave, HYATTSVILLE, MD</u>			
22c. PHYSICIAN'S NAME (Type) <u>William D Rosson</u>				22d. ADDRESS <u>5701 85th Ave, HYATTSVILLE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-29-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Laschi Sons</u>				25a. RECEIVED BY REGISTRAR <u>NOV 29 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

1933

CERTIFICATE OF DEATH

1933

D.O.B.

Jan 17, 1902

Boys

Wife

1917-1920

Little boy and his mother

Little boy and his mother

Little boy and his mother

1917-1920

Little boy and his mother

1917-1920

11-2-11

Little boy and his mother

1
M
07

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12936

12946

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 2501 Queens Chapel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barker		First H Middle H Last Sapp		4. DATE OF DEATH Nov. 23 1960		Day 23 Year 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23, 1893	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LYN TYPE OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) EASTON, PENN'A	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JACOB SAPP				14. MOTHER'S MAIDEN NAME MARY FRICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 140-01-5992		17. INFORMANT MRS TERESA SAPP		Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Multiple Infarcts DUE TO (c) Arteriosclerosis of Coronary Arteries						INTERVAL BETWEEN ONSET AND DEATH 23 days 23 days 26 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Vascular Disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-22 1960 to Nov. 23 1960 , that (I) (we) last saw the deceased alive on 11-23 1960 , and that death occurred at 9:20 AM the causes and on the date stated above.							
22a. SIGNATURE Dr. Saul Swartzback, M.D.				22b. ADDRESS 1726 Egle St. New York, N.Y.		22c. PHYSICIAN'S NAME (Type) Dr. Saul Swartzback, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-26-60		23c. NAME OF CEMETERY OR CREMATORY LOCUST HILL CEMETERY		23d. LOCATION (City, town, or county) (State) DOVER, NEW JERSEY	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md.				25a. RECORD BY REGISTRAR NOV 28 1960		25b. REGISTRAR'S SIGNATURE Arthur J. Jones	

CERTIFICATE OF DEATH

1938

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12937

12947

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 62 Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 6029 Baltimore Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillyian Middle G. Last Sarton				4. DATE OF DEATH Month November Day 22 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-1-11	
9. AGE (In years last birthday) 49 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Robert A. Sarton Riverdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1-Myocardia Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2-Myocardia secondary to thrombosis of Left lateral Artery DUE TO (c) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1942</u> to <u>11-22</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-22</u> 19 <u>60</u> and that death occurred <u>11:05 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <i>John P. Clum</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-23-60	
22c. PHYSICIAN'S NAME (Type) Dr. John P. Clum, M.D.				22d. ADDRESS 6110 43rd Ave., Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 25, 1960		23c. NAME OF CEMETERY OR CHURCH Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				25a. RECEIVED BY REGISTRAR NOV 28 60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1903

1. Name of deceased
2. Sex
3. Age
4. Date of death
5. Place of death
6. Cause of death
7. Signature of physician
8. Signature of registrar

9. Name of informant
10. Address of informant
11. Signature of informant
12. Date of registration
13. Registrar's signature
14. Registrar's name
15. Registrar's address

16. Name of informant
17. Address of informant
18. Signature of informant
19. Date of registration
20. Registrar's signature
21. Registrar's name
22. Registrar's address

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12948

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Landoner Md</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Geo General</i>		d. STREET ADDRESS <i>Box 470</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Schofield</i> <i>MILTON</i> First Middle Last		4. DATE OF DEATH <i>Nov 27</i> 19 <i>60</i> Month Day Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-14-18</i>
9. AGE (In years last birthday) <i>42</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clark</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Laundry</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Milton H. Schofield</i>		14. MOTHER'S MAIDEN NAME <i>Marie E. Nace</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-09-5013</i>	
17. INFORMANT <i>Marie E. Schofield</i>		Address <i>Box 470 Landoner Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Congestive Heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>myocardial infarct</i> DUE TO (c) <i>occlusion left Descending Branch</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary artery - Hypertensive Cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs</i> <i>1 1/2 hrs</i> <i>1 1/2 hrs</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dayton O Watkins</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-30-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Bladensburg, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. CHAMBERS CO.</i>		ADDRESS <i>Riverdale, Md.</i>	
24a. REC'D BY REGISTRAR <i>NOV 29 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

MEDICAL CERTIFICATION

15032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF DEATH [Faint text]	
5. PLACE OF DEATH [Faint text]		6. OCCUPATION [Faint text]		7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]	
9. SIGNATURE OF EXAMINER [Faint text]		10. SIGNATURE OF WITNESS [Faint text]		11. SIGNATURE OF JURY [Faint text]		12. SIGNATURE OF CORONER [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF NEXT OF KIN [Faint text]		15. SIGNATURE OF MINISTER OF RELIGION [Faint text]		16. SIGNATURE OF CHURCH CLERK [Faint text]	
17. SIGNATURE OF BURIAL CLERK [Faint text]		18. SIGNATURE OF FUNERAL HOME [Faint text]		19. SIGNATURE OF CEMETERY [Faint text]		20. SIGNATURE OF INTERVIEWER [Faint text]	
21. SIGNATURE OF INTERVIEWER [Faint text]		22. SIGNATURE OF INTERVIEWER [Faint text]		23. SIGNATURE OF INTERVIEWER [Faint text]		24. SIGNATURE OF INTERVIEWER [Faint text]	
25. SIGNATURE OF INTERVIEWER [Faint text]		26. SIGNATURE OF INTERVIEWER [Faint text]		27. SIGNATURE OF INTERVIEWER [Faint text]		28. SIGNATURE OF INTERVIEWER [Faint text]	
29. SIGNATURE OF INTERVIEWER [Faint text]		30. SIGNATURE OF INTERVIEWER [Faint text]		31. SIGNATURE OF INTERVIEWER [Faint text]		32. SIGNATURE OF INTERVIEWER [Faint text]	
33. SIGNATURE OF INTERVIEWER [Faint text]		34. SIGNATURE OF INTERVIEWER [Faint text]		35. SIGNATURE OF INTERVIEWER [Faint text]		36. SIGNATURE OF INTERVIEWER [Faint text]	
37. SIGNATURE OF INTERVIEWER [Faint text]		38. SIGNATURE OF INTERVIEWER [Faint text]		39. SIGNATURE OF INTERVIEWER [Faint text]		40. SIGNATURE OF INTERVIEWER [Faint text]	
41. SIGNATURE OF INTERVIEWER [Faint text]		42. SIGNATURE OF INTERVIEWER [Faint text]		43. SIGNATURE OF INTERVIEWER [Faint text]		44. SIGNATURE OF INTERVIEWER [Faint text]	
45. SIGNATURE OF INTERVIEWER [Faint text]		46. SIGNATURE OF INTERVIEWER [Faint text]		47. SIGNATURE OF INTERVIEWER [Faint text]		48. SIGNATURE OF INTERVIEWER [Faint text]	
49. SIGNATURE OF INTERVIEWER [Faint text]		50. SIGNATURE OF INTERVIEWER [Faint text]		51. SIGNATURE OF INTERVIEWER [Faint text]		52. SIGNATURE OF INTERVIEWER [Faint text]	
53. SIGNATURE OF INTERVIEWER [Faint text]		54. SIGNATURE OF INTERVIEWER [Faint text]		55. SIGNATURE OF INTERVIEWER [Faint text]		56. SIGNATURE OF INTERVIEWER [Faint text]	
57. SIGNATURE OF INTERVIEWER [Faint text]		58. SIGNATURE OF INTERVIEWER [Faint text]		59. SIGNATURE OF INTERVIEWER [Faint text]		60. SIGNATURE OF INTERVIEWER [Faint text]	
61. SIGNATURE OF INTERVIEWER [Faint text]		62. SIGNATURE OF INTERVIEWER [Faint text]		63. SIGNATURE OF INTERVIEWER [Faint text]		64. SIGNATURE OF INTERVIEWER [Faint text]	
65. SIGNATURE OF INTERVIEWER [Faint text]		66. SIGNATURE OF INTERVIEWER [Faint text]		67. SIGNATURE OF INTERVIEWER [Faint text]		68. SIGNATURE OF INTERVIEWER [Faint text]	
69. SIGNATURE OF INTERVIEWER [Faint text]		70. SIGNATURE OF INTERVIEWER [Faint text]		71. SIGNATURE OF INTERVIEWER [Faint text]		72. SIGNATURE OF INTERVIEWER [Faint text]	
73. SIGNATURE OF INTERVIEWER [Faint text]		74. SIGNATURE OF INTERVIEWER [Faint text]		75. SIGNATURE OF INTERVIEWER [Faint text]		76. SIGNATURE OF INTERVIEWER [Faint text]	
77. SIGNATURE OF INTERVIEWER [Faint text]		78. SIGNATURE OF INTERVIEWER [Faint text]		79. SIGNATURE OF INTERVIEWER [Faint text]		80. SIGNATURE OF INTERVIEWER [Faint text]	
81. SIGNATURE OF INTERVIEWER [Faint text]		82. SIGNATURE OF INTERVIEWER [Faint text]		83. SIGNATURE OF INTERVIEWER [Faint text]		84. SIGNATURE OF INTERVIEWER [Faint text]	
85. SIGNATURE OF INTERVIEWER [Faint text]		86. SIGNATURE OF INTERVIEWER [Faint text]		87. SIGNATURE OF INTERVIEWER [Faint text]		88. SIGNATURE OF INTERVIEWER [Faint text]	
89. SIGNATURE OF INTERVIEWER [Faint text]		90. SIGNATURE OF INTERVIEWER [Faint text]		91. SIGNATURE OF INTERVIEWER [Faint text]		92. SIGNATURE OF INTERVIEWER [Faint text]	
93. SIGNATURE OF INTERVIEWER [Faint text]		94. SIGNATURE OF INTERVIEWER [Faint text]		95. SIGNATURE OF INTERVIEWER [Faint text]		96. SIGNATURE OF INTERVIEWER [Faint text]	
97. SIGNATURE OF INTERVIEWER [Faint text]		98. SIGNATURE OF INTERVIEWER [Faint text]		99. SIGNATURE OF INTERVIEWER [Faint text]		100. SIGNATURE OF INTERVIEWER [Faint text]	

15032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.
M
177
I
2
2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1293 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12940

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier d. STREET ADDRESS 3107 Bunker Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARRIE ELIZABETH SHENK		4. DATE OF DEATH Month November Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Francis		14. MOTHER'S MAIDEN NAME Isabelle Williamson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph C. Shenk, 3107 Bunker Hill, Rd.		Address Mt. Rainier, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial hypertrophy - Congestive DUE TO heart failure. Arrhythmia of the liver (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial Nov. 15, 1960		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.		24a. REC'D BY REGISTRAR NOV 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

13011 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 DEPARTMENT OF HEALTH
 Prince George
 Mount Rainier
 Prince George General Hospital 3107 Bunker Hill Road
 November 9, 1960
 CARLIE ELIZABETH BROWN
 Female White
 At Home
 Tennessee
 U.S.A.
 Isabelle Williamson
 Joseph G. Brown, 3107 Bunker Hill Rd.
 Mt. Rainier, Md.
 None None
 James I. Ryan, M.D.
 November 11, 1960
 Arlington, Virginia
 W. W. CHAMBERS CO., Riverdale, Md.
 Nov. 15, 1960 Arlington National

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Glen Argen Woods</u> d. STREET ADDRESS <u>13204 Hayes St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clayton Brian Simpkins</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>19 60</u>		5. SEX <u>Male</u>			
6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 5, 1958</u>		9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward W. Simpkins, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy E. Williamson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>E.W. Simpkins -- as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> DUE TO <u>492X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-9-60</u>			
EXAMINER'S NAME (Type) <u>Dayton O Watkins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-14-60</u>		22b. DATE THEREOF <u>11-14-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balington Nat.</u>			
22d. LOCATION (City, town, or county) <u>Arlington Virginia</u>		22e. (State) <u> </u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington & Son</u>		ADDRESS <u>4925 Deane Gap</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 14 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		24c. (State) <u> </u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12988

CERTIFICATE OF DEATH

Reg. Dist. No.

12951

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN lb 7 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5806-28th Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle O. Last SLAUGHTER		4. DATE OF DEATH Month November Day 18th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	11. BIRTHPLACE (State or foreign country) New York
13. FATHER'S NAME Ora Chrissman		14. MOTHER'S MAIDEN NAME Margaret Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Wm. E. Slaughter 5806-28th Ave., S.E.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 300.1 DUE TO (c) 300.1 DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 weeks 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
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20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from January 1960 to Nov. 18, 1960, that I last saw the deceased alive on Oct. 21, 1960, and that death occurred at 255 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Charles E. Woodson M.D.	ADDRESS (Street, city or town, state) 1801 Eye St. N.W. Washington 6, D.C.	DATE SIGNED Nov. 18-1960
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 21-1960	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Imogene L. Jones		24a. REC'D BY REGISTRAR DATE NOV 21 '60	
ADDRESS 1661--Good Hope Rd. SE Washington 20 DC		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12989

CERTIFICATE OF DEATH

Reg. Dist. No.

12952

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pri. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchelville				c. LENGTH OF STAY IN 1b 5yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Box 134			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Gas Middle Smith Last Smith				4. DATE OF DEATH Month Nov Day 16 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 21 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 19 Days 16 Hours 16 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tenant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Smith				14. MOTHER'S MAIDEN NAME Eliza Coates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Mary Smith		Address Md. Box 34 Mitchelville,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiac Vascular Renal Disease DUE TO (c) 10 yrs						INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Sept 1960 to 16 Nov 1960 , that I last saw the deceased alive on 16 Nov 1960 , and that death occurred at 6:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. B. Bassor		M.D. Upper Marlboro Md		ADDRESS (Street, city or town, State) 16 Nov 60		DATE SIGNED	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-60		22c. NAME OF CEMETERY OR CREMATORY St. Marys Church		22d. LOCATION (City, town, or county) (State) Groome, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thelma R. Ballins				ADDRESS 4339 Hunt Pl., N.E. Washington, D.C.		24a. REC'D BY REGISTRAR Nov 21 '60	
				24b. REGISTRAR'S SIGNATURE Cindora S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15088

Reg. Dist. 14

NAME OF DECEASED JAMES H. HAYES		SEX Male		AGE 65		DATE OF BIRTH 1873		PLACE OF BIRTH Baltimore, Md.		RACE White		OCCUPATION Retired		EDUCATION High School		MARRIAGE Married		RELIGION Methodist		US. CITIZENSHIP Naturalized		MILITARY SERVICE None		VETERAN None		DATE OF DEATH 1938		PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		SIGNATURE OF REGISTRAR J. H. Hayes		DATE OF REGISTRATION 1938		OFFICE OF REGISTRATION Baltimore, Md.																									
FATHER'S NAME JAMES H. HAYES		MOTHER'S NAME JANE H. HAYES		FATHER'S OCCUPATION None		MOTHER'S OCCUPATION None		FATHER'S PLACE OF BIRTH Baltimore, Md.		MOTHER'S PLACE OF BIRTH Baltimore, Md.		FATHER'S DATE OF BIRTH 1873		MOTHER'S DATE OF BIRTH 1873		FATHER'S MARRIAGE Married		MOTHER'S MARRIAGE Married		FATHER'S RELIGION Methodist		MOTHER'S RELIGION Methodist		FATHER'S US. CITIZENSHIP Naturalized		MOTHER'S US. CITIZENSHIP Naturalized		FATHER'S MILITARY SERVICE None		MOTHER'S MILITARY SERVICE None		FATHER'S VETERAN None		MOTHER'S VETERAN None		FATHER'S DATE OF DEATH None		MOTHER'S DATE OF DEATH None		FATHER'S PLACE OF DEATH None		MOTHER'S PLACE OF DEATH None		FATHER'S CAUSE OF DEATH None		MOTHER'S CAUSE OF DEATH None		FATHER'S MANNER OF DEATH None		MOTHER'S MANNER OF DEATH None		FATHER'S SIGNATURE None		MOTHER'S SIGNATURE None		FATHER'S DATE OF REGISTRATION None		MOTHER'S DATE OF REGISTRATION None		FATHER'S OFFICE OF REGISTRATION None		MOTHER'S OFFICE OF REGISTRATION None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12941

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12953

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 7219 Patterson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John R. Stark				4. DATE OF DEATH Month Day Year Nov. 5 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 June 1902	
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Driver - Olympia Bakery				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Stark				14. MOTHER'S MAIDEN NAME Mamie Sutphin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Mrs. Minnie Stark- 7219 Patterson St. Lanham, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Memia Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Chronic pyelonephritis DUE TO (c) 10 yr. INTERVAL BETWEEN ONSET AND DEATH 18 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10/19 1960 to 11/5 1960 , that (I) (we) last saw the deceased alive on 11/5 1960 , and that death occurred at 7:00 AM from the causes and on the date stated above.							
22a. SIGNATURE Dr. Charles D. Connor, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Charles D. Connor, M.D.				22d. ADDRESS 4410 74th Ave - Landover Hills Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/8/60		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Prince Georges County, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.				ADDRESS		25a. REC'D BY REGISTRAR NOV 7 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12942

CERTIFICATE OF DEATH

Reg. Dist. No.

12954

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>cheverly</u>				c. LENGTH OF STAY IN 1b <u>5 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad-SACORDA CONVALESCENT HOME</u>				d. STREET ADDRESS <u>7369 Brinkley Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>S</u> Last <u>STAUFFER</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 5 1890</u>	
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Diehl</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>PAUL W. STAUFFER</u>				Address <u>7369 BRINKLEY RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, viral</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Syns</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>72 hrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>Nov 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 19</u> , 19 <u>60</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Comenau</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>11/19/60</u>			
PHYSICIAN'S NAME (Type) <u>Norman Donat Comenau</u>				M.D. <u>MT Raimier MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11.22.60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home. 300. 4th st N E.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 28 '60</u> DATE	
						24b. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>	

1

18948

CENTRAL DEPT.

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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12990
12955
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b DEAD ON ARRIVAL d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, ANDREWS AFB, WASH, DC		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY P.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 2812 KEITH STREET, SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMERSON Middle LEROY Last STOCKS		4. DATE OF DEATH Month NOVEMBER Day 12 Year 19 60			
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 NOVEMBER 1927	9. AGE (In years lost birthday) 33 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEDICAL TECHNICIAN		10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME ERNEST FRANKLIN STOCKS		14. MOTHER'S MAIDEN NAME DECEASED	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. FEB 1946-60 234-38-9570		17. INFORMANT AIR FORCE PERSONNEL RECORDS Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 INFARCTION OF MYOCARDIUM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 7 MONTHS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 30 12 Nov 60 to 19 30 12 Nov 60, that (I) (we) last saw the deceased alive on 19 30 12 Nov 60, and that death occurred at 730 PM, from the causes and on the date stated above.					
22a. SIGNATURE Albert D Carilli		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12 Nov 60	
22c. PHYSICIAN'S NAME (Type) ALBERT D CARILLI, CAPT USAF (MC)		22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 16 Nov. 1960		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	
23d. LOCATION (City, town, or county) ARLINGTON VA.		23e. REC'D BY REGISTRAR DATE NOV 15 '60		23f. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1938

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1938

DECEASED IN HOME

1. NAME OF DECEASED

2. SEX AND AGE

3. OCCUPATION

4. CAUSE OF DEATH

5. PLACE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. COUNTY

11. CITY

12. STATE

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12956

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Axon Run</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Axon Run</u>			
c. LENGTH OF STAY IN 1b <u>3 years</u>				d. STREET ADDRESS <u>12519 Southern Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2519 Southern Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Florentyna Strzalkowska</u>				4. DATE OF DEATH <u>Nov 1 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 22, 1901</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>3 H. Strzalkowski Wash. DC</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Asphyxia</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Hanging</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self from Venetian blind in bay</u>					
20c. TIME OF INJURY Month, Day, Year <u>Nov 1 - 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Axon Run P.G. Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James T. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>11-1-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4 Nov. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>WASHINGTON DC</u>	
23. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME</u> ADDRESS <u>816 H St. NE DC 2</u>				24a. REC'D BY REGISTRAR <u>NOV 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1. Name of Deceased
2. Age
3. Sex
4. Color
5. Occupation
6. Residence
7. Date of Death
8. Place of Death
9. Cause of Death
10. Manner of Death
11. Signature of Examiner
12. Signature of Coroner
13. Signature of Physician
14. Signature of Juror
15. Signature of Juror
16. Signature of Juror
17. Signature of Juror
18. Signature of Juror
19. Signature of Juror
20. Signature of Juror

1. Name of Deceased
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13. Signature of Physician
14. Signature of Juror
15. Signature of Juror
16. Signature of Juror
17. Signature of Juror
18. Signature of Juror
19. Signature of Juror
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13. Signature of Physician
14. Signature of Juror
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6. Residence
7. Date of Death
8. Place of Death
9. Cause of Death
10. Manner of Death
11. Signature of Examiner
12. Signature of Coroner
13. Signature of Physician
14. Signature of Juror
15. Signature of Juror
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17. Signature of Juror
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4. Color
5. Occupation
6. Residence
7. Date of Death
8. Place of Death
9. Cause of Death
10. Manner of Death
11. Signature of Examiner
12. Signature of Coroner
13. Signature of Physician
14. Signature of Juror
15. Signature of Juror
16. Signature of Juror
17. Signature of Juror
18. Signature of Juror
19. Signature of Juror
20. Signature of Juror

1. Name of Deceased
2. Age
3. Sex
4. Color
5. Occupation
6. Residence
7. Date of Death
8. Place of Death
9. Cause of Death
10. Manner of Death
11. Signature of Examiner
12. Signature of Coroner
13. Signature of Physician
14. Signature of Juror
15. Signature of Juror
16. Signature of Juror
17. Signature of Juror
18. Signature of Juror
19. Signature of Juror
20. Signature of Juror

12992

CERTIFICATE OF DEATH

Reg. Dist. No.

12957

1. PLACE OF DEATH a. COUNTY <u>Prince Georges Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>16 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faulkner</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Southern Maryland Hospital Center</u>				d. STREET ADDRESS <u>0 8X-2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Grace</u> Last <u>Swann</u>				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-4-22</u>		9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Proctor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>William H. Thompson (brother)</u>		Address <u>Port Tobacco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema & embolus</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>11/13</u> , 19 <u>60</u> , to <u>11/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>60</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard Schneider</u> M.D.				ADDRESS (Street, city or town, state) <u>Southern Maryland Hosp</u>		DATE SIGNED <u>11/14/60</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD SCHNEIDER</u>				<u>Clinton Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-16-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cmn.</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heath Funeral Home</u>				ADDRESS <u>Waldorf Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

15005

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
12943
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12959

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 1 1008 60th St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Lilly Thompson				4. DATE OF DEATH Nov 4 19 60			
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) H. C.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Robert Davis				14. MOTHER'S MAIDEN NAME Sarah Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT William Thompson				Address Sarnes #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days 30 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10/29 19 60 to Nov 4 19 60 , that (I) (we) lost saw the deceased alive on 11/4 19 60 , and that death occurred at 3:20 PM from the causes and on the date stated above.							
22a. SIGNATURE Dr. Connors, MD				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Connors, MD				22d. ADDRESS 4410-74th Ave, Landover, Md.			
23a. URN, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 11-9-60			
23c. NAME OF CEMETERY OR CREMATORY Nat. Harmony				23d. LOCATION (City, town, or county) (State) Landover Md			
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Sons				25a. REC'D BY REGISTRAR NOV 10 '60			
25b. REGISTRAR'S SIGNATURE W. S. Frazier							

CERTIFICATE OF DEATH

13048

Blank form with horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR AIS (4)
ISM 9/59

12892

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12961

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>47 X-3</u> b. COUNTY <u>WASHINGTON D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR 4922 LA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE BELLE ALLAN TRIMBLE</u>		4. DATE OF DEATH <u>NOVEMBER 25 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1-1867</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR <u>5</u> Months <u>24</u> Days	IF UNDER 24 HRS. <u>5</u> Hours <u>24</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>HOUSTON TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>HARRY L. ALLAN</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE MORGAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Dr. Agnes Patricia</u>		Address <u>4922 LA Halle Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERIO SCLEROSIS</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>2 years</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>dearth as ulcer of hip & chronic osteomyelitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>60</u> to <u>Nov 25</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 25</u> 19 <u>60</u> , and that death occurred at <u>1:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Leon S. Tarkenton MD</u>		22b. DATE SIGNED <u>11/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon S. Tarkenton</u>		22d. ADDRESS <u>3408 R.I. AVE. MT. RAINIER, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/26/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FRANKFORT</u>		23d. LOCATION (City, town, or county) (State) <u>FRANKFORT, KENTUCKY</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joe. Hawley's Sons Inc.</u>		ADDRESS <u>1756 Pa. Ave. NW.</u>	
25a. REC'D BY REGISTRAR <u>NOV 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

15803

CENTER OF DEATH

RECORDS AND INFORMATION OF DEATH

RECORDS AND INFORMATION OF DEATH

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12993 CERTIFICATE OF DEATH

12962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aguasco</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Olive</u> First <u>Watson</u> Middle <u>Trueman</u> Last				4. DATE OF DEATH <u>November 5</u> 19 <u>60</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 2, 1886</u> 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Poplar Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELI Watson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Trueman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Robert H. Trueman, Aguasco, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senescent Cardiac-vascular Renal Atrophy</u> DUE TO (c) <u>Age Process</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>year</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>60</u> , to <u>11-5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11-5</u> , 19 <u>60</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert H. Trueman</u> M.D.				DATE SIGNED <u>November 14, 1960</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Meth. Baden, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Baden, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hays</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12960

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chillum c. LENGTH OF STAY IN lb MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY None c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4020 8th Street N. E.		
3. NAME OF DECEASED (Type or print) MAXTON RANDOLPH TURNER			4. DATE OF DEATH Month November Day 21 , Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 11, 1903	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Bole Turner			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 579-01-2924		17. INFORMANT Mrs. Dona Turner, same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 Coronary occlusion DUE TO (b) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) 11-21-60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 25, 1960	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or country) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.,		ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR NOV 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

MEDICAL CERTIFICATION

15094 HISTORICAL EXHIBITS & CORRESPONDENCE OF GEORGE

Prince George County D. C. None

Onlinum Washington

5036 Ridge Road 4030 8th Street N. E.

Male White NANTON RANDOLPH TURNER November 21, 60.

JAMES I. BOYD, M.D.

Nov. 22, 1960 Fort Lincoln Cemetery, Bladenburg, Maryland

W. V. CHAMBERS CO., Riverdale, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12949

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12963

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.B.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. LENGTH OF STAY IN 1b about 3 mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 34 Lakeside Drive		d. STREET ADDRESS 1 34 Lakeside Dr.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LEONS Vasilis		4. DATE OF DEATH Month Day Year Nov 10 1960	
5. SEX Male	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/1894
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Worked in Cafeteria)		10b. KIND OF BUSINESS OR INDUSTRY Doctors Hospital	
11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? Latvia	
13. FATHER'S NAME Andrea Vasilis		14. MOTHER'S MAIDEN NAME Karlina Bromulds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-44-8886	
17. INFORMANT Mrs. Marta Vasilis-34 Lakeside Drive Greenbelt, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac decompensation 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1969 to Nov 10 1966 that (I) (we) last saw the deceased alive on 5:25 AM Nov 10 1966, and that death occurred at 5:38 AM, from the causes and on the date stated above.			
22a. SIGNATURE William C. Weintraub		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William C. Weintraub		22d. ADDRESS 9 E Parkway, Greenbelt, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/60	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25a. REC'D BY REGISTRAR NOV 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12965

12945

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb 6 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 6702 Patterson St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Blanche		First V		Middle Vetter		Last Nov. 28	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1899	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Department Store	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME George Reeder		14. MOTHER'S MAIDEN NAME May Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records Cheverly Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardiovascular-Renal disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from about Sept 15, 1960 to Nov. 28, 1960 , that (I) (we) last saw the deceased alive on 19 60 , and that death occurred at 3:35 P. from the causes and on the date stated above.							
22a. SIGNATURE Wm. C. Weintraub				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. C. Weintraub ; M.D.				22d. ADDRESS Greenbelt, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/1/60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1501

CENTRAL DATE OF DEATH

1910-1911

1912-1913

1914-1915

1916-1917

1918-1919

1920-1921

1922-1923

1924-1925

1926-1927

1928-1929

1930-1931

1932-1933

1934-1935

1936-1937

1938-1939

1940-1941

1942-1943

1944-1945

1946-1947

1948-1949

1950-1951

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

1972-1973

1974-1975

1976-1977

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12944

12964

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George General</i>		d. STREET ADDRESS <i>6401 Seabrook Road</i>	
3. NAME OF DECEASED (Type or print) First <i>CORA</i> Middle <i>G.</i> Last <i>VAUGHN</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>25</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>July 29 1903</i>
9. AGE (In years last birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self</i>	
11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>George Whetzel</i>		14. MOTHER'S MAIDEN NAME <i>Emma J. Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Betty Biggs Murphy Seabrook Acres Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>350X Pneumonia</i> DUE TO (b) <i>Parkinson's Disease</i> DUE TO (c) <i>Dehydration</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Extensive decubitus ulcers.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct. 26, 1960</i> to <i>Nov 25, 1960</i> , that (I) met last saw the deceased alive on <i>Nov 24, 1960</i> , and that death occurred at <i>9 A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Francis X Carrillo</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Francis X Carrillo</i>		22d. ADDRESS <i>1013 Univ. Blvd. E. Silver Spring Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov 28, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Bergton Lutheran Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Bergton Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons Hyattsville, Md.</i>		ADDRESS	
25a. REC'D BY REGISTRAR <i>NOV 29 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

NOTES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12893

CERTIFICATE OF DEATH

Reg. Dist. No. 12966

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>ARLINGTON</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE NURSING HOME</u>		d. STREET ADDRESS <u>2629 WASH. BLVD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE W. WARD, Sr.</u>		4. DATE OF DEATH Month Day Year <u>11 21 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17-1868</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>	
11. BIRTHPLACE (State or foreign country) <u>Augusta, Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Anson Tillson Ward</u>		14. MOTHER'S MAIDEN NAME <u>Mary Robbins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-12-7334</u>	
17. INFORMANT <u>Clarence W. Ward, Sr.</u>		Address <u>Hilleah, Fla.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular-renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 12</u> , 19 <u>60</u> , to <u>Nov 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 21</u> , 19 <u>60</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Clements</u> M.D.		ADDRESS (Street, city or town, state) <u>6001-35th Ave</u>	
DATE SIGNED <u>11/21/60</u>			
PHYSICIAN'S NAME (Type) <u>William H Clements</u>		<u>Hyattsville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-23-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home, Inc</u> <u>C. P. [unclear]</u>		ADDRESS <u>Arlington, Va.</u>	
24a. RECEIVED BY REGISTRAR DATE <u>NOV 28 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. [unclear]</u>	

CERTIFICATE OF DEATH

15293

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. WARD		45		M		W		1880		BALTIMORE		MD		MD		USA	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1905		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
EDUCATION		SCHOOLING		REMARKS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
HIGH SCHOOL		12		HEART DISEASE		NATURAL		HOME		BALTIMORE		MD		MD		USA	
OCCUPATION		BUSINESS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH		STATE OF DEATH	
BUSINESS		1925		BALTIMORE		MD		MD		USA		BALTIMORE		MD		USA	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGY		SIGNATURE OF CLERGY		SIGNATURE OF CLERGY		SIGNATURE OF CLERGY		SIGNATURE OF CLERGY	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH	
1925		BALTIMORE		MD		MD		USA		BALTIMORE		MD		MD		USA	

15293

15293

RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12995

12967

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Highland Park c. LENGTH OF STAY IN 1b 5 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1206 70th Street		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Highland Park d. STREET ADDRESS 1206 70th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRIETTA First WASHINGTON Middle WASHINGTON Last		4. DATE OF DEATH November 22, 1960 Month November Day 22 Year 1960	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 26, 1904 Month Dec Day 26 Year 1904	
9. AGE (In years last birthday) 55 IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Wilmington N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT William Washington Highland Pk., Md.		Address 1206 70th St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia Exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Carcinomatosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 199.2		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED November 22, 1960.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-26-60	
22c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		22d. LOCATION (City, town, or country) (State) Seat Pleasant, Md.	
23. FUNERAL DIRECTOR ROLLINS FUNERAL HOME, Washington, D.C.		24a. REGISTRAR'S SIGNATURE Arthur L. Evans	

NOV 28 '60

(M)

(I)

Prince George	Maryland	1200 70th Street	5 Years	1200 70th Street	5 Years	1200 70th Street	5 Years
Washington	Washington	Washington	Washington	Washington	Washington	Washington	Washington
November 22, 1960	November 22, 1960	November 22, 1960	November 22, 1960	November 22, 1960	November 22, 1960	November 22, 1960	November 22, 1960
U.S.A.	U.S.A.	U.S.A.	U.S.A.	U.S.A.	U.S.A.	U.S.A.	U.S.A.
Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
None	None	None	None	None	None	None	None
William Washington	William Washington	William Washington	William Washington	William Washington	William Washington	William Washington	William Washington
1200 70th St.	1200 70th St.	1200 70th St.	1200 70th St.	1200 70th St.	1200 70th St.	1200 70th St.	1200 70th St.

Generalized Convulsions

Toxic Reaction

Unknown

None

Unknown

William Washington

1200 70th St.

U.S.A.

November 22, 1960

ROLLING FURNACE, WASHINGTON, D.C.

NOVEMBER 22, 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12996

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12968

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CHARLES</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BRANDYWINE-WALDORF CLINIC</u>		d. STREET ADDRESS <u>08X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES ALEXANDER WHEELER</u>		4. DATE OF DEATH Month Day Year <u>NOV 5 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 12, 1912</u>
9. AGE (In years lost birthday) <u>48</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HIGHWAY MAINTENANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATE ROAD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ARTHUR JAMES WHEELER</u>		14. MOTHER'S MAIDEN NAME <u>ESTELLE CHASE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-16-7865</u>	
17. INFORMANT <u>MRS. SARAH WHEELER, LA PLATA, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>Carcinoma of Stomach</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-18</u> 19 <u>60</u> , to <u>11-5</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11-5</u> 19 <u>60</u> , and that death occurred at <u>2</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Dobson</u>		22b. DATE SIGNED <u>11-5-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>		22d. ADDRESS <u>Brandywine Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-9-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		23d. LOCATION (City, town, or county) (State) <u>LA PLATA, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>THE HUNT FUNERAL HOME, WALDORF, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

STATE OF CALIFORNIA
COUNTY OF []
CERTIFICATE OF DEATH

15088

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

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DATE OF REINTERMENT

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12969

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN lb D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 1615 Park Ave.,			
3. NAME OF DECEASED (Type or print) Katherine Mae Whistler				4. DATE OF DEATH November 11, 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 20, 1892	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Adam Brown Croushorn		14. MOTHER'S MAIDEN NAME Mollie Colner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 227-10-3571		17. INFORMANT Mildred B. Lynn		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of the base of the skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Occupant of an auto that went out of control		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 11-11-1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 198 + 1/2 S. Laurel Rd.		20f. (City or town) Laurel		20g. (County) Harford		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED November 12, 1960.				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 14 1960		22c. NAME OF CEMETERY OR CREMATORY National Memorial		22d. LOCATION (City, town, or country) (State) Halls Church, Virginia	
23. FUNERAL DIRECTOR DONALDSON FUNERAL HOME, Laurel, Md.				24a. REC'D BY REGISTRAR NOV 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

100-100000

George George

Maryland

Bellevue

Riverdale

D.O.A.

Baltimore

Land Memorial Hospital

1015 Park Ave.

Katherine

Age

Master

November 11, 1900

Female White

Nov. 30, 1892

Practical Nurse

Working

Virginia

U.S.A.

Adam Brown Greenhorn

Nellie Bolner

627-10-3511 Mildred B. Lynn, Laurel, Maryland.
107 Dear Route.

JAMES I. BOND, M.D.

November 12, 1900.

Donaldson Funeral Home, Laurel, Md.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12946

12970

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges E MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle C Last Whitcraft				4. DATE OF DEATH Month Nov Day 13 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Feb 1892		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman				10b. KIND OF BUSINESS OR INDUSTRY Govt. Printing Off.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Walter C. Whitcraft				14. MOTHER'S MAIDEN NAME Doretta Doremus			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1				16. SOCIAL SECURITY NO. WW 1			
17. INFORMANT Edith H. Whitcraft (Wife)				Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and Toxemia 541-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Peritonitis DUE TO (c) Ruptured Duodenal Ulcer INTERVAL BETWEEN ONSET AND DEATH 48 hours 48 hours 48 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple old myocardial infarcts secondary to Coronary Arterioscl. HT. DS. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from NW. 19 60 to NW. 13 19 60 that (I) (we) last saw the deceased alive on NW 12 19 60 , and that death occurred on 555 AM from the causes and on the date stated above.							
22a. SIGNATURE Ronald S Fleischer M.D.				22b. DATE SIGNED NOV 13 19 60			
22c. PHYSICIAN'S NAME (Type) Dr. Ronald S Fleischer M.D.				22d. ADDRESS 5432 Queens Chapel Rd. Hyattsville., Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/16/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraw							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12997
CERTIFICATE OF DEATH

12971

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1110 Eye St., N. E.	
3. NAME OF DECEASED (Type or print) First William Middle W. Last White		4. DATE OF DEATH Month 11 Day 21 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/1900
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY D.C. Sanitation Dept.	
11. BIRTHPLACE (State or foreign country) Elmo, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas White		14. MOTHER'S MAIDEN NAME Jennie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 577-36-9082	
17. INFORMANT Decedent		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.,	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of left pleura, primary site undetermined; left thoracotomy, 10/28/60; cor pulmonale		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/7/1960 to 11/21/1960, that (I) (we) last saw the deceased alive on 11/21/1960, and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss, M. D.		22b. DATE SIGNED 11/21/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11.26.60	
23c. NAME OF CEMETERY WOODLAWN		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert G. McKinnis		25a. REC'D BY REGISTRAR DATE NOV 28 '60	
ADDRESS 1820-9th St. W.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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CERTIFICATE OF DEATH

Reg. Dist. No.

12972

12948

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston				c. LENGTH OF STAY IN 1b 20 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4924 Lafayette Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAISY Middle MARY Last WIGHINGTON				4. DATE OF DEATH Month November Day 18 Year 1960.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 27 1889	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CURRENCY TRIMMER		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES AUBREY Dove			
14. MOTHER'S MAIDEN NAME Margaret Mary Birch				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Gloria A. Yarmola, College Pk., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20 , 19 57 , to Nov. 18 , 19 60 , that I last saw the deceased alive on November 18 , 19 60 , and that death occurred at 10:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Md. 5701 85th Ave., Carrollton, Md. DATE SIGNED 11/18/60.							
ACTUAL SIGNATURE William D. Rosson				M.D. 5701 85th Ave., Carrollton, Md.			
PHYSICIAN'S NAME (Type) WILLIAM D. ROSSON, M.D.				5701 85th Ave., Carrollton, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 22, 1960		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE NOV 23 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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T OF HEALTH-BALTIMORE

Page 4
 TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9-50

12998

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12973

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 20, D.C.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 1438 ALABAMA AVE. S.E.			
3. NAME OF DECEASED (Type or print) First Middle Last QUENTIN DERMONT Womack				4. DATE OF DEATH Month Day Year November 4 1960			
5. SEX male	6. COLOR OR RACE Neg	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 NOV 60	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months Days 1 7	IF UNDER 24 HRS. Hours Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WARREN Q Womack				14. MOTHER'S MAIDEN NAME MURPHY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NA		17. INFORMANT WARREN Q WOMACK (FATHER)		Address SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 31 HOURS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 2 19 60 to Nov. 4 19 60 that (I) was last saw the deceased alive on Nov. 4 19 60 , and that death occurred at 1:00 AM, from the causes and on the date stated above.							
22a. SIGNATURE John R. Delahunty M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov. 4, 1960	
22c. PHYSICIAN'S NAME (Type) JOHN R DELAHUNTY, CAPT USAF (MC)				22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25,			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-9-60		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR'S SIGNATURE B.F. TAYLOR <i>B.F. Taylor</i>				ADDRESS 909 6TH ST, N.W. D.C.		25a. REC'D BY REGISTRAR DATE NOV 9 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

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1911

PRINCE GEORGE'S COUNTY, MARYLAND

CHAPLIN, JAMES

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CERTIFICATE OF DEATH

Reg. Dist. No. 12974

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>P. Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MD</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Belle Nursing Home</i>		d. STREET ADDRESS <i>11807 Owens Rd S.E.</i>	
3. NAME OF DECEASED (Type or print) First <i>DAVID</i> Middle <i>AHMAN</i> Last <i>WOODCOCK</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 20 - 60</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington DC</i>	
13. FATHER'S NAME <i>Floyd B Woodcock</i>		14. MOTHER'S MAIDEN NAME <i>Mary M^e Grath</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>11807 Owens Rd S.E.</i>	
17. INFORMANT <i>Address</i>		12. CITIZEN OF WHAT COUNTRY?	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>325.4 Congenital heart disease (acute cardiac collapse)</i> DUE TO (b) <i>Mongolism</i> DUE TO (c) <i>lying cause lost.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>birth on</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 24</i> , 19 <i>60</i> , to <i>11/11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>11/11</i> , 19 <i>60</i> , and that death occurred at <i>10:20</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas A. Christensen</i>		ADDRESS (Street, city or town, state) <i>6905 Belts Blvd</i>	
PHYSICIAN'S NAME (Type) <i>THOMAS A. CHRISTENSEN</i>		DATE SIGNED <i>11/11/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>	22b. DATE THEREOF <i>Nov 12-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Smithland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>SIMMONS BROS</i>		24a. REC'D BY REGISTRAR <i>NOV 14 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

<p>NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>AGE</p> <p><i>45</i></p>
<p>SEX</p> <p><i>Male</i></p>		<p>DATE OF BIRTH</p> <p><i>Jan 15 1879</i></p>
<p>PLACE OF BIRTH</p> <p><i>San Francisco, Cal.</i></p>		<p>DATE OF DEATH</p> <p><i>Dec 10 1924</i></p>
<p>CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>PLACE OF DEATH</p> <p><i>Home</i></p>
<p>DIAGNOSIS</p> <p><i>Myocardial Infarction</i></p>		<p>DATE OF INTERVIEW</p> <p><i>Dec 15 1924</i></p>
<p>REPORTED BY</p> <p><i>Dr. J. H. Smith</i></p>		<p>SIGNATURE OF REPORTER</p> <p><i>J. H. Smith</i></p>
<p>DATE OF REPORT</p> <p><i>Dec 15 1924</i></p>		<p>DATE OF FILING</p> <p><i>Dec 15 1924</i></p>
<p>FILE NO.</p> <p><i>100-12345</i></p>		<p>REMARKS</p> <p><i>See serial 100-12345</i></p>

This is a duplicate of the original certificate of death filed in the office of the Registrar of Births and Deaths, Department of Health, State of Hawaii.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

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12999

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12975

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD (DISTRICT OF COLUMBIA) b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 40 MIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, WASH 25 DC		d. STREET ADDRESS 3712 WELTHAM ST SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELSON Middle THOMAS Last WRIGHT		4. DATE OF DEATH Month NOVEMBER Day 8 Year 19 60			
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 11, 1883	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET ARMY 1ST LT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME EDWARD A. WRIGHT		14. MOTHER'S MAIDEN NAME MARGURITE CASSIDY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1916-19 42-45 002-10-7513		17. INFORMANT EDWARD N WRIGHT (SON) Address SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED ABDOMINAL ANEURYSM 451A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) / DUE TO (c) /		INTERVAL BETWEEN ONSET AND DEATH 12 HOURS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 0130 8 NOV 1960 to 0210 NOV 1960 , that (I) (we) last saw the deceased alive on 8 NOV 1960 , and that death occurred at 0210 M, from the causes and on the date stated above.					
22a. SIGNATURE Andrew W. Butchko		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8 NOV 60	
22c. PHYSICIAN'S NAME (Type) ANDREW W BUTCHKO CAPT USAF (MC)		22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-10-60		23c. NAME OF CEMETERY OR CREMATORY PLYMOUTH MASS.	
23d. LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME, INC. 816 H ST. N.E.		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 10 '60	
25b. REGISTRAR'S SIGNATURE Charles E. Kiana					

